NEUROLOGY CENTER OF FAIRFAX, LTD.

Fairfax Office 3020 Hamaker Ct, Suite 400, Fairfax, VA 22031
Reston Office 1830 Town Center Dr, Suite 305, Reston, VA 20190
Office Phone 703.876.0800 | Fax 703.876.0866
After hours emergency 703.755.1450

Review of Systems

Name: _____ **DOB:** _____ **Date:** _____

CONSTITUTIONAL SYMPTOMS		VISUAL SYMPTOMS		GYNECOLOGICAL SYMPTOMS	
Weight Change	☐YES ☐NO	Blurry vision	☐YES ☐NO	Other	☐YES ☐NO
Chills/fever	☐YES ☐NO	Double vision	☐YES ☐NO	**SLEEP SYMPTOMS**	
Fatigue	☐YES ☐NO	Loss of vision	☐YES ☐NO	Snoring	☐YES ☐NO
Other	☐YES ☐NO	Seeing flashing lights	☐YES ☐NO	Gasping at night	☐YES ☐NO
HEAD AND NECK SYMPTOMS		Other	☐YES ☐NO	Insomnia	☐YES ☐NO
Headaches	☐YES ☐NO	**EARS, NOSE, AND THROAT SYMPTOMS**		Daytime sleepiness	☐YES ☐NO
Facial pain	☐YES ☐NO	Hearing loss	☐YES ☐NO	Restless legs	☐YES ☐NO
Neck pain	☐YES ☐NO	Ringing in ears	☐YES ☐NO	Other	☐YES ☐NO
➥ Pain radiating to arms	☐YES ☐NO	Vertigo, dizziness, lightheadedness	☐YES ☐NO	**NEUROLOGICAL SYMPTOMS**	
Other	☐YES ☐NO		☐YES ☐NO	Headache	☐YES ☐NO
SKIN SYMPTOMS		Taste disturbance	☐YES ☐NO	Visual symptoms	☐YES ☐NO
Hives	☐YES ☐NO	Smell disturbance	☐YES ☐NO	Facial pain	☐YES ☐NO
Itching	☐YES ☐NO	Other	☐YES ☐NO	Memory lapse or loss	☐YES ☐NO
Rash	☐YES ☐NO	**GENITOURINARY SYMPTOMS**		Confusion/disorientation	☐YES ☐NO
Other	☐YES ☐NO	Urinary frequency	☐YES ☐NO	Generalized pain	☐YES ☐NO
HEMATOLOGICAL SYMPTOMS		Urinary urgency	☐YES ☐NO	Localized pain	☐YES ☐NO
Bleeding or bruising	☐YES ☐NO	Urinary loss of control	☐YES ☐NO	➥ Head	☐YES ☐NO
Other	☐YES ☐NO	Urinary tract infection	☐YES ☐NO	➥ Neck	☐YES ☐NO
RESPIRATORY SYMPTOMS		Sexual dysfunction	☐YES ☐NO	➥ Arms	☐YES ☐NO
Shortness of breath	☐YES ☐NO	Other	☐YES ☐NO	➥ Torso	☐YES ☐NO
Infections	☐YES ☐NO	**MUSCULOSKELETAL SYMPTOMS**		➥ Legs	☐YES ☐NO
Other	☐YES ☐NO	Back pain	☐YES ☐NO	Numbness	☐YES ☐NO
GASTROINTESTINAL SYMPTOMS		➥ Pain radiating to legs	☐YES ☐NO	➥ Head	☐YES ☐NO
Difficulty swallowing	☐YES ☐NO	Neck pain	☐YES ☐NO	➥ Neck	☐YES ☐NO
Abdominal pain	☐YES ☐NO	➥ Pain radiating to arms	☐YES ☐NO	➥ Arms	☐YES ☐NO
Ulcer disease	☐YES ☐NO	Joint pains	☐YES ☐NO	➥ Torso	☐YES ☐NO
Liver disease	☐YES ☐NO	Pain in arms/hands	☐YES ☐NO	➥ Legs	☐YES ☐NO
Bowel problems	☐YES ☐NO	Pain in legs/feet	☐YES ☐NO	Fatigue - feeling tired	☐YES ☐NO
Other	☐YES ☐NO	Muscle weakness	☐YES ☐NO	Tremor	☐YES ☐NO
ENDOCRINE SYMPTOMS		Muscle pain/aches	☐YES ☐NO	Unsteady walking/wobbly	☐YES ☐NO
Diabetes	☐YES ☐NO	Muscle twitches/fasciculations	☐YES ☐NO	Falls	☐YES ☐NO
Hot or cold intolerance	☐YES ☐NO	Muscle cramps	☐YES ☐NO	Convulsions/seizures	☐YES ☐NO
Other	☐YES ☐NO	Other	☐YES ☐NO	Fainting/passing out	☐YES ☐NO
CARDIOVASCULAR SYMPTOMS		**PSYCHOLOGICAL SYMPTOMS**		Stroke	☐YES ☐NO
Heart disease	☐YES ☐NO	Anxiety	☐YES ☐NO	Head injury/concussion	☐YES ☐NO
Angina - Chest pain	☐YES ☐NO	Depression	☐YES ☐NO	➥ with loss of consciousness	☐YES ☐NO
Irregular heartbeat	☐YES ☐NO	Hallucinations	☐YES ☐NO	Spinal cord disease	☐YES ☐NO
Other	☐YES ☐NO	Other	☐YES ☐NO	Other	☐YES ☐NO

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Past Medical History

Does the patient have a history of any of the following:

Hypertension	☐ YES ☐ NO	**Blood disorder**	☐ YES ☐ NO
Liver disease	☐ YES ☐ NO	**Bladder problems**	☐ YES ☐ NO
Kidney disease	☐ YES ☐ NO	**Bowel problems**	☐ YES ☐ NO
Seizure disorder	☐ YES ☐ NO	**Multiple sclerosis**	☐ YES ☐ NO
Parkinson's disease	☐ YES ☐ NO	**Vision loss/double vision**	☐ YES ☐ NO
Autoimmune disease	☐ YES ☐ NO	**Memory loss**	☐ YES ☐ NO
Psychiatric disorder	☐ YES ☐ NO	**Cancer**	☐ YES ☐ NO
Gallbladder disease	☐ YES ☐ NO	**Arthritis**	☐ YES ☐ NO
Endocrine disease	☐ YES ☐ NO	**Gynecologic problems**	☐ YES ☐ NO
Diabetes Mellitus	☐ YES ☐ NO	☐ Type 1 ☐ Type 2	
Heart disease	☐ YES ☐ NO	☐ Coronary artery disease/Angina ☐ Heart attack ☐ Atrial fibrillation	
Thyroid disease	☐ YES ☐ NO	☐ Hyper- ☐ Hypo- ☐ Hashimoto's	
Gastrointestinal disorder	☐ YES ☐ NO	☐ GI Bleed ☐ Reflux/GERD ☐ Bowel problems	
Lung disease	☐ YES ☐ NO	☐ Asthma ☐ COPD	
Sleep disturbances	☐ YES ☐ NO	☐ Sleep apnea ☐ Narcolepsy ☐ Insomnia	
Headaches	☐ YES ☐ NO	☐ Migraines ☐ Other Headache	
Muscle disease	☐ YES ☐ NO	☐ Myasthenia gravis ☐ Fibromyalgia	
Stroke/TIA	☐ YES ☐ NO	☐ Carotid disease/stenosis ☐ Intracranial hemorrhage	
Nerve disease	☐ YES ☐ NO	☐ Neuropathy ☐ Nerve pain ☐ Sciatica	
Radiculopathy	☐ YES ☐ NO	☐ Cervical ☐ Lumbar ☐ Thoracic	
Surgery	☐ YES ☐ NO	List:	

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Family Medical History

Please list any family history pertaining to your parents and siblings:

Hypertension	☐ YES ☐ NO	**Diabetes**	☐ YES ☐ NO
Heart disease	☐ YES ☐ NO	**Stroke**	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	**Memory Loss**	☐ YES ☐ NO
Gastrointestinal disorder	☐ YES ☐ NO	**Multiple Sclerosis**	☐ YES ☐ NO
Liver disease	☐ YES ☐ NO	**Autoimmune disease**	☐ YES ☐ NO
Kidney disease	☐ YES ☐ NO	**Thyroid disease**	☐ YES ☐ NO
Lung disease	☐ YES ☐ NO	**Parkinson's disease**	☐ YES ☐ NO
Seizures	☐ YES ☐ NO	**Headaches/Migraines**	☐ YES ☐ NO
Eye disease	☐ YES ☐ NO	**Nerve disease**	☐ YES ☐ NO
Sleep disorder	☐ YES ☐ NO	**Muscle disease**	☐ YES ☐ NO
Other Illnesses	If yes, please list: _____ _____ _____ _____		
☐ **My family history is unobtainable due to being adopted**			
☐ **My family history is unknown**			

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Social History

Are you:

- ☐ Right-handed
- ☐ Left-handed

Do you drink or use caffeine?

- ☐ Yes
- ☐ No

Do you use tobacco products?

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown

Do you drink Alcohol?

- ☐ Yes, socially
- ☐ Yes, 2 or fewer drinks a day
- ☐ Yes, 2 or more drinks a day
- ☐ No

What are your exercise habits?

- ☐ Good exercise habits (more than 3 days a week)
- ☐ Poor exercise habits

What is your occupational status?

- ☐ Full-time as a(n) _____
- ☐ Part-time as a(n) _____
- ☐ Homemaker
- ☐ Currently on disability
- ☐ Unemployed
- ☐ Retired
- ☐ Student
- ☐ Military Service

What is your marital status?

- ☐ Currently Married
- ☐ Domestic Partner
- ☐ Single
- ☐ Separated
- ☐ Divorced
- ☐ Widowed