Neuroendocrine Associates
Tamara L. Wexler, MD, PhD

New Patient form

Please fill out to the best of your ability. Dr. Wexler reads each form.

Patient's Name (Last, First) ______________________ **Date of Birth**: ______________

Reason for today's visit/ top questions to address: ____

____

Referring physician: _________________________ Referring physician's #: _________________

Referring physician's email or fax #: ______________________________________

Pharmacy name|address|telephone: ______________________________________

Emergency name|telephone|relationship: ____

MEDICAL PROBLEMS / DIAGNOSES *(current and past):* Please list. Attach additional sheets if needed.

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CONCUSSION HISTORY: Please briefly describe your concussion incident(s), if any, and dates:

____
____
____
____

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SURGICAL HISTORY: Please list. Attach additional sheets if needed

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____

Have you ever been hospitalized overnight for reasons other than surgery? If so, please list:

____

SOCIAL HISTORY / HEALTH HABITS:

Relationship Status: ______________ Alcohol use (check one): No |Yes : # /day _________

Smoking/tobacco: Never | Former (quit date _____)| Current (_____*per day,* ____ *yrs)*

Occupation: _________________________ Relationship status:___________________________

Who else lives in your household? ___________________

____

Do you have resources for emotional support? ______________________________________

How is your sleep? ____

How often do you exercise? Types of exercise? ____

FAMILY HISTORY Please provide health information about your family members, including grandparents and siblings.

RELATION	HEALTH PROBLEM(S)
Father	
Mother	
Siblings	
Other:	

ALLERGIES

MEDICATION ALLERGIES	REACTION

MEDICATIONS/VITAMINS/SUPPLEMENTS:

NAME OF MEDICATION/ VITAMIN/ OTC	DOSE (how much)	FREQUENCY	HELPFUL?

NAME OF SUPPLEMENT/ HERB	DOSE (how much)	FREQUENCY	REASON FOR TAKING

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YOUR SYMPTOMS Mark **(×)** next to symptoms that you have experienced in the last 4 weeks

GENERAL	☐ Weight loss ☐ Fevers or Chills	☐ Weight gain ☐ Loss of appetite	☐ Increased appetite
EYES	☐ Vision loss (including peripheral vision) ☐ Blurry vision		☐ Double vision
EAR, NOSE, THROAT	☐ Voice hoarseness	☐ Neck swelling/mass	☐ Loss of smell
CARDIOVASCULAR	☐ Chest pain	☐ Palpitations	☐ Leg swelling
RESPIRATORY	☐ Cough	☐ Wheezing	☐ Breathlessness
GASTROINTESTINAL	☐ Abdominal pain ☐ Nausea	☐ Vomiting	☐ Diarrhea
GENITOURINARY	☐ Frequent urination	☐ Urgency to urinate	☐ Painful urination
MUSCULOSKELETAL	☐ Noted change in strength/ ability to exercise		☐ Joint pain
SKIN/HAIR	☐ Increased body hair ☐ Rash	☐ Loss of body hair	☐ Loss of scalp hair
NEUROLOGIC/ MOOD	☐ Headache ☐ Loss of Consciousness ☐ Depressed mood	☐ Confusion ☐ Recent difficulty with memory /concentration ☐ Anxiety	☐ Dizziness ☐ Irritability
ENDOCRINE	☐ Cold sensitivity ☐ Milk production (other than breastfeeding)	☐ Heat sensitivity	☐ Irregular menstrual period

Is there anything else you would like Dr. Wexler to know?