Neurology Institute of Melbourne * Richard M. Unger, Jr., MD * 116 Silver Palm Ave Melbourne, FL 32901 * 321-725-6999

# PATIENT HISTORY UPDATE

**NAME:** _____ **DATE:** _____ **PRIMARY CARE PHYS:** _____

**SMOKING STATUS:** CURRENT _____ PER DAY FORMER _____YEAR QUIT **NEVER**

**ALCOHOL STATUS:** REGULAR____PER DAY OCCASIONAL_____PER DAY RARE_____ PER MONTH **NEVER**

HAVE YOU **EXPERIENCED** OR **BEEN TREATED** FOR ANY OF THE FOLLOWING SINCE YOUR LAST VISIT

| SYMPTOM | SINCE LAST VISIT | | PLEASE EXPLAIN |
|---|---|---|---|
| EYE PROBLEMS | NEW | NONE | |
| EAR PROBLEMS | NEW | NONE | |
| NOSE PROBLEMS | NEW | NONE | |
| LUNG PROBLEMS | NEW | NONE | |
| HEART PROBLEMS | NEW | NONE | |
| URINARY / KIDNEY PROBLEMS | NEW | NONE | |
| DIGESTIVE / LIVER PROBLEMS | NEW | NONE | |
| MALE OR FEMALE ORGANS | NEW | NONE | |
| BONE PROBLEMS | NEW | NONE | |
| SKIN PROBLEMS | NEW | NONE | |

**PLEASE CIRCLE THE APPROPRIATE RESPONSE AND EXPLAIN IN THE SPACE PROVIDED. IF YOU DO NOT HAVE THE SYMPTOM, PLEASE CIRCLE "N/A"**

| | | | | | |
|---|---|---|---|---|---|
| FAINTING | MORE | LESS | SAME | N/A | |
| DIZZINESS | MORE | LESS | SAME | N/A | |
| LIGHTHEADEDNESS | MORE | LESS | SAME | N/A | |
| LOSS OF MEMORY | MORE | LESS | SAME | N/A | |
| TREMORS / SHAKING | MORE | LESS | SAME | N/A | |
| SEIZURES | MORE | LESS | SAME | N/A | |
| NUMBNESS / TINGLING | MORE | LESS | SAME | N/A | |
| NECK PAIN | MORE | LESS | SAME | N/A | |
| BACK PAIN | MORE | LESS | SAME | N/A | |
| DIFFICULTY WALKING | MORE | LESS | SAME | N/A | |
| DIFFICULTY WITH BALANCE | MORE | LESS | SAME | N/A | |
| DIFFICULTY WITH SPEECH | MORE | LESS | SAME | N/A | |
| HEADACHE | MORE | LESS | SAME | N/A | |
| INCONTINENCE | MORE | LESS | SAME | N/A | |

**HAVE YOU HAD ANY SURGERIES SINCE YOUR LAST APPOINTMENT. IF YES, PLEASE LIST THE TYPE OF SURGERY AND THE DATE IT WAS DONE.**

YES NO _____

HAVE YOU BEEN DIAGNOSED OR RECEIVED TREATMENT FOR ANY OF THE FOLLOWING **SINCE YOUR LAST VISIT WITH DR. UNGER?**

| | | | |
|---|---|---|---|
| BLOOD PRESSURE PROBLEMS | YES | NO | |
| DIABETES | YES | NO | |
| CHOLESTEROL PROBLEMS | YES | NO | |
| HEART DISEASE | YES | NO | |
| THYROID PROBLEMS | YES | NO | |

**NEUROLOGY INSTITUTE OF MELBOURNE** **DR. RICHARD M. UNGER, JR., M.D.**

**NAME:** _____ **DATE:** _____

# PAIN ASSESSMENT

Do you have pain in the following areas:

If you answered yes, please continue. **If you do not answer it will be assumed that there is nothing to make your pain worse.**

Is the pain in your **NECK**? YES NO Is the pain: INTERMITTENT CONSTANT

On a scale of 1-10, 10 being the worst what is your pain level: **1 2 3 4 5 6 7 8 9 10**

Is the pain: SHARP DULL BURNING STABBING THROBBING **What makes the pain worse?** _____

Is the pain in your **THORACIC SPINE** (between your shoulder blades)? YES NO Is the pain: INTERMITTENT CONSTANT

On a scale of 1-10, 10 being the worst what is your pain level: **1 2 3 4 5 6 7 8 9 10**

Is the pain: SHARP DULL BURNING STABBING THROBBING **What makes the pain worse?** _____

Is the pain in your **LOWER BACK**? YES NO Is the pain: INTERMITTENT CONSTANT

On a scale of 1-10, 10 being the worst what is your pain level: **1 2 3 4 5 6 7 8 9 10**

Is the pain: SHARP DULL BURNING STABBING THROBBING **What makes the pain worse?** _____

Is the pain in your **FEET/LEGS**? YES NO Is the pain: INTERMITTENT CONSTANT

On a scale of 1-10, 10 being the worst what is your pain level: **1 2 3 4 5 6 7 8 9 10**

Is the pain: SHARP DULL BURNING STABBING THROBBING **What makes the pain worse?** _____

Is the pain in your **HANDS/ARMS**? YES NO Is the pain: INTERMITTENT CONSTANT

On a scale of 1-10, 10 being the worst what is your pain level: **1 2 3 4 5 6 7 8 9 10**

Is the pain: SHARP DULL BURNING STABBING THROBBING **What makes the pain worse?** _____

Is the pain in your **FACE**? YES NO Is the pain: INTERMITTENT CONSTANT

On a scale of 1-10, 10 being the worst what is your pain level: **1 2 3 4 5 6 7 8 9 10**

Is the pain: SHARP DULL BURNING STABBING THROBBING **What makes the pain worse?** _____

Is the pain in your **JOINTS**? YES NO Is the pain: INTERMITTENT CONSTANT

Which Joints? _____

On a scale of 1-10, 10 being the worst what is your pain level: **1 2 3 4 5 6 7 8 9 10**

Is the pain: SHARP DULL BURNING STABBING THROBBING **What makes the pain worse?** _____

Patient Signature: _____ Physician Signature: _____

(Form reviewed with patient)

NEUROLOGY INSTITUTE OF MELBOURNE DR. RICHARD M. UNGER, JR., M.D.

NAME: _____ DATE: _____

# MEMORY (COGNITIVE) ASSESSMENT

Can you handle **DRIVING** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Can you handle **COOKING** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Can you handle **FINANCES** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Can you handle **MEDICATIONS** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Can you handle **FEEDING** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Can you handle **DRESSING** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Can you handle **BATHING** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Can you handle **TOILETING** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Patient Signature: _____ Physician Signature: _____

(Form reviewed with patient)

NEUROLOGY INSTITUTE OF MELBOURNE DR. RICHARD M. UNGER, JR., M.D.

NAME: _____ DATE: _____

# HEADACHE ASSESSMENT

Do you get headaches? **YES** **NO** If yes, please fill out the form below.

What side is your headaches? **RIGHT** **LEFT** **BOTH SIDES**

On a scale of 1-10, 10 being the worst what is your headache pain level: **1 2 3 4 5 6 7 8 9 10**

Where are your headaches located on your head? **FRONT** **BACK** **SIDE** **EYES** **FACE** **TEMPLES**

How often do you experience headaches? _____ How Long do the headaches last? _____

How long have you had headaches? _____

What type of pain is the headaches? **SHARP** **DULL** **THROBBING**

Do you have any of the following (circle all that apply):
**LIGHT SENSITIVITY** **SOUND SENSITIVITY** **SMELL SENSITIVITY** **NAUSEA/VOMITING**

Are your headaches sudden or gradual in onset? **SUDDEN** **GRADUAL**

Do you have an aura (warning before headache) such as flashing lights? **YES** **NO**

Do you have other symptoms with the headaches? **VISUAL DISTURBANCE** **SPEECH DISTURBANCE** **FOCAL WEAKNESS/NUMBNESS** PLEASE CLARIFY: _____

What do you take for your headaches when they occur to get them to go away?

_____

List all preventative (daily) medications you are currently taking.

_____ _____

List all preventative (daily) medications you have taken for headaches in the past.

_____ _____

Since last visit has the frequency of the headaches increased or decreased? **INCREASED** **DECREASED** **SAME**

Any change in the type of headaches since last visit? _____

Patient Signature: _____ Physician Signature: _____
(Form reviewed with patient)

NAME: _____ DATE: _____

# PARKINSON'S ASSESSMENT

Do you have Parkinson's disease? **YES NO**

If yes, what year were you diagnosed? _____

Do you have a DBS (Deep Brain Stimulator)? **YES NO**

When was it implanted? _____ By Whom? _____

What medication are you taking for Parkinson's? **LIST DOSAGE AND TIME(S) OF DAY TAKEN**

Sinemet (carbidopa / Levodopa) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Sinemet CR (long acting Carbidopa / Levodopa) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Mirapex (Pramipexole) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Requip (Ropinerol) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Neupro (Rotigotine) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Azilect (Rasagiline) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Eldepryl (Selegiline) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Symmetrel (Amantidine) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Comtan (Entacapone) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Artane (trihexyphenidyl) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Apokyn (Apomorphine) Injecton ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Tasmar (Tolcapone) Injection ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Rytary ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Does the medication control your symptoms from dose to dose? **YES NO**

If not, what symptoms are you experiencing in between doses? _____

Do you have dyskinesia (uncontrolled abnormal snake like movement)? **YES NO**

Do you experience hallucinations or delusions? **YES NO**

Do you get episodes of lightheadedness when you stand up? **YES NO**

Do you have memory loss? **YES NO** If so, how long? _____

Patient Signature: _____ Physician Signature: _____

(Form reviewed with patient)