

**ANTHONY G. ALESSI, M.D.**  
**NEURO DIAGNOSTICS, LLC**  
**MEDICAL INFORMATION FORM**

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_  
(First) (Middle) (Last)

Chief Complaint: \_\_\_\_\_

Circle One: Right Handed    Left Handed    HT: \_\_\_\_\_ WT: \_\_\_\_\_ Are You Pregnant? Yes \_\_\_ No \_\_\_

Smoker: \_\_\_\_\_ Pack/Day    Non-Smoker: \_\_\_\_\_ # of Years    Alcohol: \_\_\_\_\_ # Drinks/Day

Please list current medications (include Vitamins and Supplements): \_\_\_\_\_

List Surgery(s) and Date(s): \_\_\_\_\_

Allergies: \_\_\_\_\_

Please **CHECK** Yes or No – Do you have or ever had:

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
___	___	Cancer – If Yes, When _____	___	___	Pain/Numbness – If Yes, Where _____
		Treatment Performed _____	___	___	Asthma – If Yes, What Inhalers _____
___	___	Diabetes – If Yes, # of Years _____	___	___	Pacemaker – If Yes, Date Inserted _____
___	___	Seizures – If Yes, When Diagnosed _____	___	___	Heart Attack – If Yes, When _____
___	___	Head Trauma(Concussion)–If Yes, When _____	___	___	Hypertension (High Blood Pressure) _____
___	___	Stroke/TIA – If Yes, When Diagnosed _____	___	___	Hepatitis _____
___	___	Migraines(Headaches) – If Yes, # of Years _____	___	___	Arthritis _____
___	___	Thyroid Disease _____	___	___	Depression _____
___	___	Vertigo (Dizziness) _____	___	___	Other _____
			___	___	Stroke _____
			___	___	Brain Aneurysm _____
			___	___	Other _____

**Family History:**

\_\_\_ \_\_\_ Heart Disease \_\_\_\_\_  
\_\_\_ \_\_\_ Diabetes \_\_\_\_\_  
\_\_\_ \_\_\_ Neurological Disease \_\_\_\_\_

Please **CIRCLE** any of the following symptoms you are experiencing:

- General:**    Weight Loss    Weight Gain
- GI:**    Nausea    Vomiting    Difficulty Chewing    Difficulty Swallowing    Heartburn    Diarrhea    Constipation
- GU:**    Urinary Retention    Urinary Frequency    Incontinence
- Psychiatric:**    Depression    Mood Swings    Confusion
- Cardiac:**    Shortness of Breath on Exertion    Chest Pain    Palpitations
- Nasal:**    Nosebleeds    Sinus Infections    Congestion
- Respiratory:**    Persistent Cough    Wheezing
- Auditory:**    Ringing in Ears    Ear Pain    Hearing Loss
- Visual:**    Glasses or Contacts    Double Vision    Visual Changes    Eye Pain
- Vascular:**    Leg Pain when Walking    Swelling of Ankles    Cold Limbs
- Sleep:**    Insomnia    Excessive Sleepiness    Daytime Sleepiness
- Spine:**    Neck Pain    Low Back Pain
- Neurological:**    Headaches    Weakness    Numbness    Loss of Conscious

