Neurology Consultants of Kansas
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(316) 261 - 3220

Neurological Clinical Summary

Name: _____
LAST FIRST MI

Date of Birth: _____ Age: _____

☐ Right handed ☐ Left handed ☐ Ambidextrous

Referring Physician: _____

Primary Care Physician: _____

Main problem you would like the physician to address: _____

_____

_____

_____

_____

Current Medication and Dosages: (example: 50 mg twice daily) – If more, please attach list of medications

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Tests for Current Problems (CT Scans, MRI, blood work, EEG, etc)

1. _____
2. _____
3. _____
4. _____
5. _____

Past Medical History (significant illnesses, injuries, hospitalizations, hypertension, heart problems, cancer, seizures, headaches)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Family History (list any epilepsy, strokes, mental retardation, cancer, diabetes, lupus, muscle or nerve disorders, psychiatric illnesses, etc.)

Father: (Age) ☐ Living ☐ Deceased

_____

_____

Mother: (Age) ☐ Living ☐ Deceased

_____

_____

Siblings (include ages): _____

_____

_____

Past Treatments for This Problem

_____

_____

_____

_____

Past Surgical History: (list any previous operations, approximate year and surgeon)

1. _____
2. _____
3. _____
4. _____
5. _____

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Tobacco Use: ☐ Yes ☐ No ☐ Previous use

_____# packs per day for _____ years

_____ # years since quit

Alcohol use: ☐ Yes ☐ No

Caffeine use: ☐ Yes ☐ No

Occupation: _____

_____

_____

Allergies to Medications (list medication and effect, e.g. rash)

Medication Reaction

_____

_____

_____

REVIEW OF SYSTEMS:

General:

- ☐ recent weight change
  - ☐ gain
  - ☐ loss

  (# lbs in past 6 months _____)
- ☐ fatigue
- ☐ fevers
- ☐ poor appetite
- ☐ poor concentration
- ☐ recent stressors ☐ anxiety

Cardiovascular:

- ☐ chest pain
- ☐ heart attack

Respiratory:

- ☐ shortness of breath
- ☐ cough

Sleep:

- ☐ trouble getting to sleep
- ☐ trouble staying asleep
- ☐ snoring
- ☐ trouble breathing during sleep
- ☐ urge to move legs at bedtime
- ☐ daytime drowsiness

Developmental:

Any known problems with your birth: ☐ yes ☐ no

Developmental milestones reached in a normal fashion (walked, talked, rode bicycle): ☐ yes ☐ no

Nervous System:

- ☐ febrile seizures
- ☐ seizures
- ☐ temporary slurred speech
- ☐ difficulty swallowing
- ☐ numbness, tingling, or burning
- ☐ weakness
- ☐ stroke
- ☐ headaches
- ☐ head injury with loss of consciousness
- ☐ blackouts
- ☐ memory disturbance
- ☐ dizziness
- ☐ tremor

Muscle, Joints, Skin:

- ☐ joint pain
- ☐ muscle pain/tenderness
- ☐ joint swelling/redness
- ☐ rash

Digestive:

- ☐ nausea/vomiting
- ☐ diarrhea

Urinary:

- ☐ incontinence
- ☐ urgency
- ☐ frequency
- ☐ loss of sensation
- ☐ impotence

Eyes:

- ☐ wear glasses
- ☐ cataracts
- ☐ glaucoma
- ☐ visual disturbance
  - ☐ double vision
  - ☐ temporary blindness in 1 eye
  - ☐ other

Ears:

- ☐ difficulty hearing
- ☐ pain
- ☐ ringing

Mouth, Nose and Throat:

- ☐ changes in sense of taste
- ☐ changes in sense of smell
- ☐ jaw, gum, tooth pain

Use this scale to choose the most appropriate number for each situation.

0 would never doze	1 slight chance of dozing	2 moderate chance of dozing	3 high chance of dozing

Situation	**Chance of dozing (0 to 3)**			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (e.g. a theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
Total Score				

Over the past 2 weeks, how often have you been bothered by ANY of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Physician Use Only:

IMPRESSION:

APPEARANCE

HEENT

NECK

CV

ABD

EXTR

JOINTS

BACK/SLR

SKIN

MMSE

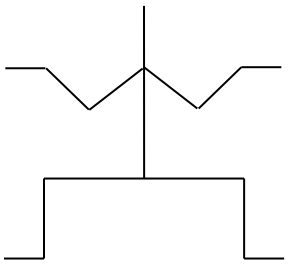
SPEECH

LANG (names, repeats)

CN

I	II	OD	OS	III / IV/ VI
V	VII	VIII	IX	
X	XI	XII		

MOTOR
- Tone
- Volume
- Movement

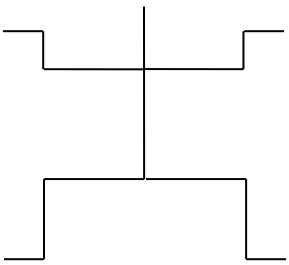


PLAN:

SENS
- PP/temp
- Light touch
- Vibration
- Position
- Romberg

DTRs

COORD
- FNF
- HS
- RAM
- FFMS



GAIT
- Stride
- Heel
- Toe
- Tandem

Hall Pike