# The Neurology Clinic of Washington

*General Neurology, Neuromuscular diseases, Movement disorders, Headaches, Sleep Disorders, Electromyography, Botulinum Toxin injections*

**Nirjal K. Nikhar, MD, FRCP; Aubreigh Godleski, PA-C, MSPAS; Yumi Jono, DNP**

**Name:** ______________________ **DOB:** ______________________ **Date:** __________

**Primary Care Physician:** ______________________ **Referring Physician:** ______________________

**Please indicate if you desire a chaperone** Yes ☐ No ☐

**Presenting complaints** [ ]

| **Past Medical History** | | | | | | **Medications** |
|---|---|---|---|---|---|---|
| Heart disease | | Lung disease | | Meningitis/Encephalitis | | |
| High cholesterol | | Thyroid disorders | | Learning disability | | |
| Hypertension | | Brain /Sp. cord injury | | Neuropathy | | |
| Diabetes | | Multiple sclerosis | | Headache / Migraine | | |
| Strokes/TIA | | Parkinson's disease | | Dementia | | |
| Sleep apnea | | Rheumatologic disease | | Neck/ Back surgery | | |
| Pacemaker | | Cancer | | Intracranial shunt | | |
| Depression | | Seizures | | **Others:** | | |
| Prostate disease | | Anxiety | | | | |

| **Review of Systems** | | | | | | **Allergies** |
|---|---|---|---|---|---|---|
| Confusion | | Fatigue | | Bladder Problems | | ☐ yes |
| Dizziness | | Weight gain/ loss | | Shortness of breath | | ☐ no |
| Headache | | Fever | | Chest pain | | |
| Balance difficulties | | Hearing loss | | Droopy eyes | | **Please list allergies** |
| Involuntary movements | | Rashes | | Double vision | | |
| Tingling/numbness | | Birth marks | | Blurred vision | | |
| Muscle weakness | | Irregular periods | | Cough | | |
| Walking difficulties | | Joint pains | | | | |
| Swallowing difficulties | | Back pain/ neck pain | | **Height:** | | |
| Memory loss | | Nausea/ vomiting | | **Weight:** | | |
| Mood changes | | Constipation | | **Right/Left-handed:** | | |

***Please make sure you complete both pages of history***

18213 Hillcrest Avenue, Olney, MD 20832

3202 Tower Oaks Boulevard, Ste. 330, Rockville, MD 20852

Tel: 301 260 7600 Fax: 240 779 2111

**Name:** ______________________ **DOB:** ______________________ **Date** ______________

| **Social History** | | |
|---|---|---|
| Caffeinated drinks, how much | | Occupation |
| **Smoking**, how much? Quit, what year? | | Married/ Single/ Widowed/ Divorced |
| Alcohol, If yes how much | | Planning pregnancy |
| Recreational drugs, either past or present | | Do you live alone? |

Please indicate which family member on the chart below. Use space below if more room is needed.

| **Family History** | |
|---|---|
| Heart disease: | Other neurological disorders: |
| Hypertension: | Migraine: |
| Diabetes: | Alcoholism: |
| Strokes/TIA: | Cancer: |
| Seizures: | **Others:** |

## ***Epworth Scale***

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following 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** |
|---|---|
| Sitting and reading | _________ |
| Watching TV | _________ |
| Sitting, inactive in a public place (e.g., a theater or a meeting) | _________ |
| As a passenger in a car for an hour without a break | _________ |
| Lying down to rest in the afternoon when circumstances permit | _________ |
| Sitting and talking to someone | _________ |
| Sitting quietly after lunch without alcohol | _________ |
| In a car, while stopped for a few minutes in the traffic | _________ |

If your score is greater than 6 points then you are sleepy. If your score is more than 10 points, you are very sleepy. If your score is more than 16 points you are dangerously sleepy.