MICHIGAN STATE UNIVERSITY
DEPARTMENT OF NEUROLOGY AND OPHTHALMOLOGY

Neuro-Ophthalmology Services

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Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone: ( )_____ Work Phone ( )_____

Right Handed _____ Left Handed _____ Age_____ Sex (circle): Male or Female

Date of Birth: _____ Place of Birth: _____ Soc.Security#_____

Referring Physician:_____ **Primary Care Physician:**_____

Address/City:_____ Address/City:_____

Phone: ( )_____ Phone: ( )_____

Please list the physicians, other than your primary care and referring physicians, who you would like to receive a report from our physician:

Physician Name Address Telephone

_____

_____

_____

Please list the names of individuals to whom your medical information may be released:

_____

_____

Please list the chief complaint that brought you to our office today:

_____

_____

_____

Please **LIST ALL MEDICATIONS** you are currently taking. This should include patches, eye drops, aspirin, birth control pills, and non-prescription drugs such as vitamins or herbs. **(Attach separate list if necessary)**

MEDICATION	DOSE/FREQUENCY	YEARS TAKEN	REASON PRESCRIBED

ALLERGIES TO MEDICATIONS? _____NO ____YES If yes, please list medication and reaction:

_____

_____

_____

PAST MEDICAL HISTORY (please include approximate dates):

Anxiety/Depression:	Cerebrovascular Disease:	Liver Disease:
Asthma:	Coronary Artery Disease:	Meningitis:
Atrial Fibrillation Chronic:	Diabetes-Type 2:	Myocardial Infarction:
Atrial Fibrillation Periodic:	Head Injury/Trauma:	Peripheral Vascular Disease:
Autoimmune Disorder:	Hyperlipidemia:	Polycystic Kidney Disease:
Brain Tumor:	Hypertension:	Renal Failure:
Cancer:	Hyperthyroidism:	Seizure disorder:
Anxiety/Depression:	Hypothyroidism:	Stroke:

Others:_____

Please list type of **surgery**, including **eye surgery** (**or laser** surgery), and approximate dates:

_____

_____

_____

PAST EYE HISTORY (including childhood):

Have you been diagnosed with any of the following (please include dates and physicians):

Macular degeneration: _____ Diabetic retinopathy: _____

Glaucoma: _____ Cataracts: _____

Amblyopia(lazy eye): _____ Strabismus ("crossed eyes"): _____

Date of last eye exam:_____ By whom:_____

Please circle that word(s) that best describe you:

I wear: glasses, contacts I am: nearsighted, farsighted

I have: astigmatism, dry eyes

Have you experienced eye trauma or been exposed to any toxic chemicals? Please describe:

_____

FAMILY MEDICAL HISTORY : (Please indicate who has the illness)

Alzheimer's:	Hyperlipidemia:	Seizure Disorders:
Balance Problems:	Hypertension:	Tremors/involuntary movements:
Breast Cancer:	Migraine:	Myocardial Infarction:
Coronary Artery Disease < age 55:	Multiple Sclerosis:	Peripheral Vascular Disease:
Depression:	Stroke < age 55:	Polycystic Kidney Disease:
Diabetes:	Parkinson's	Renal Failure:
Huntington's Disease:	Peripheral Vascular Disease:	Seizure disorder:

OTHER: _____

SOCIAL HISTORY

Employed Where? _____	Residence-Home
Retired	Residence-Assisted
Disabled	Residence-Extended
Single	High School Graduate
Divorced	College graduate
Married	Alcohol use Frequency:_____
Widowed	Drug use Frequency:_____
Domestic Partner	Tobacco Use Frequency:_____
Children How many: _____	Caffeine use Frequency:_____

REVIEW OF SYSTEMS

General
- Fever
- Chills
- Sweats
- Anorexia
- Fatigue
- Weight loss

Neuro
- Limb weakness
- Numbness/Parasthesia
- Seizures
- Tremor
- Dizziness (Vertigo)
- Transient blindness
- Frequent falls
- Frequent headaches
- Difficulty walking
- Nocturnal awakenings
- Difficulty falling asleep
- Loud snoring
- Restless legs

Eyes
- Blurring of vision
- Double vision (Diplopia)
- Vision loss
- Eye pain

ENT
- Ringing in ears
- Decreased hearing
- Nose bleeds
- Difficulty swallowing

Skin
- Rash

Respiratory
- Cough
- Difficulty breathing

Genito-urinary
- Urinary frequency
- Urinary hesitancy
- Frequent urination at night
- Incontinence

Gastro-intestinal
- Nausea
- Vomiting
- Diarrhea
- Constipation

Musculoskeletal
- Back pain
- Joint pain
- Joint swelling
- Muscle cramps
- Muscle weakness
- Stiffness
- Leg pain with exertion

Psych
- Depression
- Anxiety
- Memory loss
- Suicidal ideation
- Hallucinations
- Paranoia
- Confusion

Cardiovascular
- Chest Pain
- Palpitations
- Fainting spells/Syncope

Endocrine
- Cold intolerance
- Heat intolerance

Hematology
- Abnormal bruising
- Bleeding

Allergy
- Recurrent infections

Others:

_____

_____

_____

PREVIOUS TESTING:

Test	When	Where	Results
MRI or CT scan of Head			
MRI or CT scan of Orbits			
MRI or CT scan of Neck			
MRI or CT scan of Sinuses			
CT-PET scan			
Evoked Potentials			
Visual Fields			
EEG			
Cerebral Angiogram			
Carotid Doppler			
Lumbar Puncture/Spinal Tap			
Fluorescein Angiogram			
Blood Work			

PLEASE BRING US ANY RESULTS FROM THE ABOVE TESTS. WE WOULD ASLO LIKE TO SEE THE FILMS/CD FROM ANY SCANS YOU HAVE HAD.

Please note any additional information you think we should know:

_____

_____

_____

_____

_____

_____

QUESTIONS RELATED TO POTENTIAL TESTING:

	YES	NO
Are you claustrophobic?		
Do you have any implanted metal in your body, such as pacemaker, surgical clips, prosthetic joints, or metal flakes in your eyes?		
Do you have an allergy to iodine, shellfish or gadolinium? (contrast dyes)		
Do you have cancer? If YES, most recent Chemo/Radiation date:		
Do you have asthma?		
Do you have diabetes?		
Do you have HIV?		
Do you have a history of kidney disease or renal failure?		
Currently on Dialysis?		
If you are female, are you currently nursing or could you be pregnant?		
Is there any other reason you can not have an X-ray or MRI/MRA testing? If YES, please explain.		

Current Weight: _____

Current Height: _____

ALL INFORMATION GIVEN IN THIS FORM WILL BE TREATED AS STRICTLY CONFIDENTIAL MEDICAL INFORMATION.

Patient Name (PRINTED):_____

Patient Signature:_____Date:_____