

Date: _____

Blue Sky Neurosciences, LLC

Blue Sky Neurology, LLC & Blue Sky Outpatient Neurology, LLC

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Members, Colorado Neurological Institute

NEW PATIENT HISTORY FORM

NAME: _____ Date: _____

REFERRING PHYSICIAN: _____ Primary Care Provider: _____

DATE OF BIRTH ___/___/___ AGE _____ HANDEDNESS: Right ___ Left ___ Height _____ Weight _____

CURRENT PROBLEMS - Please list current symptoms that led to referral/appointment and date of onset:

SYMPTOMS: (experienced in the last 2 months)

- | | | |
|--|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Change in personality | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Depression | <input type="checkbox"/> Slurred speech |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Heat/Cold Intolerance | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Dizziness/vertigo |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness, where _____ |
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Tingling/burning sensation |
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Weakness, where _____ |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Other Pain _____ | <input type="checkbox"/> Muscle Cramps |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Bladder Dysfunction | <input type="checkbox"/> Muscle Spasms |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bowel Function Changes | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Poor Coordination |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Loss/decreased balance |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Involuntary movements |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Other: _____ |

PAST MEDICAL HISTORY:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Ulcers/reflux |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cataracts/blindness | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> History of cancer |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Stroke/TIA's | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Other: _____ | | |

