RAAM SAMBANDAM, MD
BOARD CERTIFIED NEUROLOGIST

SYNAPSE NEUROLOGY

Name	_____SS#_____/____/_____
Birth Date	_____/_____/_____ Marital Status ___M ___D___S____Other____
Address	Street_____City _____State _____Zip
Phone #	Cell_____Home_____Work_____ Email address_____
Pharmacy	Name_____Phone_____ Street_____City_____Zip_____
Preferred Language	English_____Spanish_____Other_____
Race	White___Black or African American____Asian____American Indian_____ Other___Prefer Not to say_____
Ethnicity	Hispanic or Latino_____ Non-Hispanic or Latino _____
Occupation	_____Dominant hand ____Right_____Left
Social History	Are you a current smoker ___Yes ____No Past Smoker ____Yes ____No____ If yes when did you quit? _____ Do you drink alcohol _____daily ____weekly ____occasionally____never How much do you drink at these times _____ Was there a time you used alcohol significantly more than now ___Yes___No

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REASON FOR YOUR VISIT WITH THE NEUROLOGIST TODAY
PRMIARY CARE PHYSICIAN_____

Other Symptoms

NO	YES		DURATION OF SYMPTOMS
		Headache	
		New vision problems	
		Speech problem	
		Swallowing problem	
		Neck pain	
		Back pain	
		Weakness in arms/hands	
		Weakness in legs/feet	
		Numbness/tingling/pain in arms/hands	
		Numbness/tingling/pain in legs/feet	
		Tremor/Abnormal movements	
		Walking/balance problems	
		Falls	
		Passing out spells	
		Seizures	
		Memory problems	

Have you had any tests for your symptoms? (MRI, CT, EMG/NCS, EEG/Labs)
What_____ When_____ Where_____

PAST MEDICAL HISTORY

PREVIOUS SURGERIES	

Allergies: Substance	Reaction
No known Drug Allergies: _____yes _____no	

Medical History

YES	NO	
		High blood pressure
		Diabetes/Pre diabetes
		High cholesterol
		History of cancer
		Heart disease

Please list other medical problems:

FAMILY HISTORY	
Is there a family history of neurological disease (stroke, seizures, brain tumor, 'nerve' problems)	
Is there a family history of any other medical problems?	

MEDICATION LIST			
Name of medication	How many per day	Dose	Prescribing physician

REVIEW OF SYSTEMS- PLEASE MARK 'YES' IF A CURRENT PROBLEM

YES	NO	
		Weight gain
		Weight loss
		Hearing change
		Ringing in ear
		Ear bleeds
		Nose bleeds
		Nasal discharge
		Nasal blockage
		Gum bleeds
		Denture use
		Shortness of breath
		Wheezing
		Coughing up blood
		Chest pain
		Rapid or irregular heart beat
		Passing out spells
		Stomach pain
		Bowel habit change
		Nausea/vomiting
		Blood in stool
		Increased urine frequency
		Pain with urination