Eric C. Drew, MD

MD Neurology

4931 Long Prairie Road, Ste 100 Flower Mound, TX 75028
Phone: 972-219-5397 Fax: 972-219-5609

New Patient Intake

Patient Name:_____ **Phone Number:**_____

Address:_____ **City/State/Zip:**_____

Date of Birth:____/____/____ **Social Security:**____/____/____

How did you hear about us?_____

CHIEF COMPLAINT: What is the main symptom that caused you to make this appointment today?

HISTORY OF PRESENT ILLNESS: Please describe when and how your symptoms began and how they've progressed.

PAST MEDICAL HISTORY: Please list any previous or current illnesses and treatments with approx.. dates.

☐ Diabetes ☐ High Blood Pressure ☐ Stroke ☐ Heart disease ☐ High Cholesterol

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CURRENT MEDICATIONS: Use back of this sheet if additional space is needed.

Medication Name	Dosage (mg)	How many times per day do you take?

MEDICATION ALLERGIES:

Medication/Substance	Reactions (e.g. rash, hives, wheezing)

SURGICAL, PREGNANCY, AND INJURIES: Please provide description and approximate date.

Surgeries/Injuries _____

_____

_____

_____

Pregnancies _____

FAMILY HISTORY: Please list any illnesses in your family members especially those that are relevant to your current problems. _____

_____

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SOCIAL HISTORY:

Marital Status:_____

How much do you weigh?_____

Occupation:_____

What is your height?_____

Have you been exposed to HIV?

○ Yes ○ No

Do you smoke cigarettes?

○ Yes - # packet per day? _____

○ Quit ○ Never

Do you drink alcohol?

○ Yes - Daily? Yes ○ No ○

○ Quit ○ Never

HAVE YOU HAD ANY OF THESE TESTS?

Test	When?	Where?
☐ MRI brain		
☐ MRI spine		
☐ CT head		
☐ CT spine		
☐ EEG		
☐ EMG		
☐ Carotid Artery		
☐ Echocardiogram		
☐ Lumbar Puncture (Spinal Tap)		

ANYTHING ELSE YOU WOULD LIKE TO TELL THE DOCTOR?