

# NEUROLOGY CONSULTANTS MEDICAL GROUP

Today's Date: \_\_\_\_\_

<b>NAME:</b> _____	<b>DATE OF BIRTH:</b> _____
<b>PHONE: (HOME)</b> _____	<b>(WORK)</b> _____
<b>(CELL)</b> _____	
<b>PHARMACY NAME:</b> _____	
<b>PHARMACY PHONE:</b> _____	

## MEDICATIONS

- |          |           |
|----------|-----------|
| 1. _____ | 9. _____  |
| 2. _____ | 10. _____ |
| 3. _____ | 11. _____ |
| 4. _____ | 12. _____ |
| 5. _____ | 13. _____ |
| 6. _____ | 14. _____ |
| 7. _____ | 15. _____ |
| 8. _____ | 16. _____ |

## ALLERGIES

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

## CURRENT VACCINES

***Are you current with your vaccinations?***

YES       NO

## SMOKING STATUS

- NON-SMOKER
- SMOKER \_\_\_\_\_ (Packs A Day)
- PREVIOUS SMOKER \_\_\_\_\_ (Years Smoked)