UPHS - NEUROLOGY Date & Time: _____
INITIAL EVALUATION/CONSULTATION

REQUESTED BY_____ NAME:
DOB:
CHIEF COMPLAINT: MRN:
HISTORY OF PRESENT ILLNESS: _____

Typical Events	1	2
Aura		
Ictal		
Postictal		
Frequency		
B/B	No	No
Tongue bite	No	No
Other injury		

Epilepsy Risk Factors/Association

- Gestation Normal
- Neonatal Normal
- Febrile sz Normal
- Mening/Enceph Normal
- Development Normal
- Head trauma Normal
- Family history Normal

AEDs Tried

- ☐ Carbamazepine
- ☐ Ethosuximide
- ☐ Felbamate
- ☐ Gabapentin
- ☐ Lamotrigine
- ☐ Levetiracetam
- ☐ Oxcarbazepine
- ☐ Phenobarb
- ☐ Phenytoin
- ☐ Tiagabine
- ☐ Topiramate
- ☐ Valproate
- ☐ Zonisamide

Neurological Review of Systems:

PMH:

ALLERGIES: NKDA
MEDICATIONS:

REVIEW OF SYSTEMS:	Normal	Abnormal (Elaborate)
Psychiatric:	☐	_____
Constitutional:	☐	_____
Skin:	☐	_____
Respiratory:	☐	_____
Cardiovascular:	☐	_____
GI:	☐	_____
GU:	☐	_____
Endocrine:	☐	_____
Musculoskeletal:	☐	_____
Hematology:	☐	_____

FAMILY HISTORY:
Develop Delay No
Epilepsy No

SOCIAL HISTORY:
Tobacco:
Alcohol:
Drugs:

EXAMINATION

Problem Focused: 1-5 * elements; Expanded Problem Focused: 6+ * ; Detailed: 12+ *; Comprehensive: all * elements, plus one cardiovascular element

CONSTITUTIONAL

* Vital Signs: (3 or more) BP _____/_____ T _____ Tmax _____ HR _____ RR _____ Wt ____

	Normal	Relevant Details (especially if abnormal)
* Appearance	☐	_____
Cardiovascular		
Neck	☐	_____
Heart	☐	_____
Peripheral vasc.	☐	_____
Other		
Chest	☐	_____
Abdomen	☐	_____
MENTAL STATUS		
* Attention	☐	_____
* Orientation	☐	_____
* Memory	☐	_____
* Language	☐	_____
Visuospatial	☐	_____
Executive	☐	_____
* Fund of knowledge	☐	_____
CRANIAL NERVES		
/Visual Acuity	☐	_____
*-Visual Fields	☐	_____
\Fundi	☐	_____
*-Pupils	☐	_____
\Eye Movements	☐	_____

* V (Trigeminal) ☐ _____
* VII (Facial) ☐ _____
* VIII ☐ _____
* IX, X ☐ _____
* XI ☐ _____
* XII ☐ _____

MOTOR

* Bulk, Tone ☐ _____
Pronator Drift ☐ _____
/ RUE ☐ _____
*- LUE ☐ _____
\ RLE ☐ _____
\LLE ☐ _____

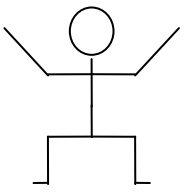
SENSORY

Light Touch ☐ _____
Pinprick ☐ _____
Temperature ☐ _____
Vibration ☐ _____
Proprioception ☐ _____
Romberg ☐ _____

COORDINATION/ GAIT

RAM ☐ _____
Finger - Nose ☐ _____
Heel - Shin ☐ _____
Tandem Walk ☐ _____

REFLEXES



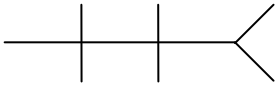
Toe: :Toe

DATA

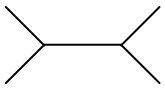
Neuroimaging:

Other Radiology:

Neurophysiology:



Ca Mg Ph



PT INR PTT

ASSESSMENT AND PLAN

☐ I have considered the patients home medications when writing admission orders

Resident Signature/Name: _____ Date & Time: _____

Pager Number: _____

ATTENDING NOTE

I have seen and examined the patient with Dr. _____, and I agree with the history, exam, assessment and plan as in the note of _____.

History:

Physical Exam:

Assessment and Plan:

Attending Signature/Name: _____ Date & Time: _____

Pager Number: _____