

**NEUROLOGY HISTORY AND
PHYSICAL FORM**

Do not write in this box



PATIENT LABEL

Date of Service: _____

Primary Care Physician:

Name: _____

Address: _____

Referring Physician:

Name: _____

Address: _____

Chief Complaint: _____

History of Present Illness: Age: _____

- Left-handed
- Right-handed
- Race _____
- Male
- Female

Neurologic Review of Systems:

(check all that apply, then describe in HPI)

- Personality/Mood change
- Hallucinations
- Cognitive change
- Language disturbance
- Difficulty chewing
- Lack of coordination
- Numbness/Tingling
- Focal Weakness
- Generalized Weakness
- Problems walking
- Bladder/Bowel problems
- Sexual Dysfunction
- Other Pain (describe): _____
- Headaches
- Altered LOC
- Lightheadedness
- Slurred speech
- Poor swallowing
- Slow movements
- Poor balance
- Convulsions

<p style="text-align: center;">THE UNIVERSITY OF KANSAS HOSPITAL KUMED 3901 Rainbow Boulevard Kansas City, Kansas 66160</p> <p style="text-align: center;">NEUROLOGY HISTORY AND PHYSICAL FORM</p>	<p>Do not write in this box</p>	<p>PATIENT LABEL</p>
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REVIEW OF SYSTEMS

Systems	DONE	Positive symptoms:
Constitutional	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	
ENT	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	
Integumentary	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	Please see the History of Present Illness section above.
Psychiatric	<input type="checkbox"/>	
Endocrine	<input type="checkbox"/>	
Hematologic/Lymphatic	<input type="checkbox"/>	
Allergic/Immunologic	<input type="checkbox"/>	

PHYSICAL EXAMINATION (Mandatory):**

VITAL SIGNS: Temp: _____ BP: _____ P: _____ RR: _____ SaO₂ _____
 Ht. _____ Wt. _____ Pain Level (0-10): _____

Atrial fibrillation/flutter present on telemetry? (circle one) **YES** **NO**

HEENT: _____

**Funduscopic exam: _____

**Carotids: _____

Lungs: _____

**Cardiac: _____

Abdomen: _____

Extremities: _____

**Peripheral vascular: _____

Skin: _____

Spine: _____

Other: _____

NEUROLOGIC EXAMINATION

Mental Status Exam: _____

Speech:

Fluency: Normal Paraphasias Stuttering Decreased output **Repetition:** Normal Impaired

Comprehension: Normal Some difficulty Unable to follow along **Naming:** Normal Impaired

Articulation: Normal Dysarthria (specify): _____

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Note: Check the box if normal

Sensory exam:

	Normal	Abnormal			
		RUE	LUE	RLE	LLE
Light touch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pin Prick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vibration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toes (sec)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ankles (sec)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fingers (sec)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Proprioception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cortical sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Simultaneous Stimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Two Point discrimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Graphesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stereognosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sensory Level _____

Gait and station:

Heel walk _____

Toe walk _____

Tandem gait _____

Romberg sign Present Absent

NIH Stroke Scale Score: _____

Glasgow Coma Score: _____

Laboratory Tests:

Diagnostic Studies:

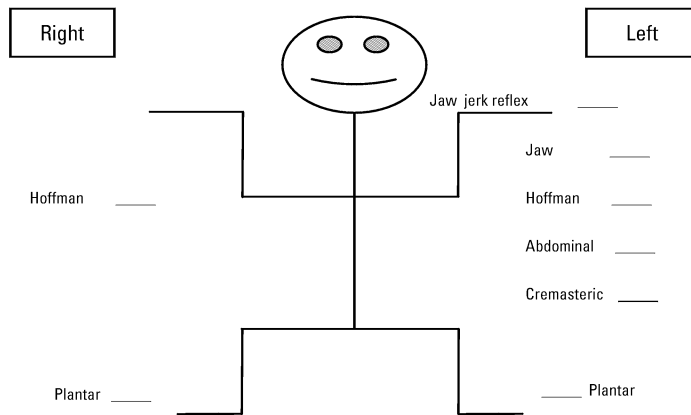
CT Head (suspected stroke/TIA): Time Read: _____ Findings: No acute ischemia No hemorrhage Other

12-lead ECG:

Review Records:

Reflexes (Grade 0, 1, 2, 3, 4):

Corneal ____ / ____ Gag ____ / ____ Oculocephalic ____ / ____
Oculovestibular ____ / ____



Coordination / Fine motor:

- Finger nose finger
- Rapid alternating movements
- Heel to shin
- Finger tap / Thumb to each finger
- Foot tap
- Other

	Abnormal	
	Right	Left
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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IMPRESSION: _____

PLAN: _____

LDL Goal (suspected stroke/TIA): <70 mg/dL <100 mg/dL _____

Education: Reviewed type of stroke, complications, and secondary stroke prevention measures with patient/family.

DVT Prophylaxis: Not indicated Indicated Sequential Compression Devices

Heparin 5000 units SQ three times daily Lovenox 40 mg SQ once daily

Code Status: Discussed _____

Not discussed _____

FACULTY REVIEW NOTES:

I have personally interviewed and examined _____ and reviewed the history,
physical examination, impression and plan of care as outlined by Dr. _____. The patient presents with
a history of: _____

On exam there is: _____

My impression is: _____

The plan is: _____

Resident Physician _____

Signature _____

Date / Time _____

Attending Physician _____

Signature _____

Date / Time _____

Dictated

Not Dictated

Dictated to send Primary/Referring Physician a copy