Arif Dalvi, MD, MBA

History & Physical

Name: _____ **Date**: _____

Age: _____ **Height**: _____ **Weight**: _____

Medical History

Diagnosis	Year	Diagnosing Physician's Name

Surgical History

Procedure	Year	Surgeon's Name

Family History

	Medical Problem	Age	Living or Deceased	Cause of Death
Mother				
Father				
Sibling				
Other				

Social History

Smoke: □ **No** □ **Yes** **Alcohol:** □ **No** □ **Yes**

Caffeine: □ **No** □ **Yes** **Drugs:** □ **No** □ **Yes**

Hand Dominance: □ **Right** □ **Left** □ **Ambidextrous**

Review of Systems

□ High blood pressure	□ Stroke	□ Tremor/shakes
□ Heart Disease	□ TIA	□ Muscle Stiffness
□ Shortness of breathe	□ Visual Disturbance	□ Slow movements
□ Diabetes	□ Depression	□ Change in posture
□ Cancer	□ Anxiety	□ Poor balance
□ Liver disease	□ Memory disorder	□ Falls
□ Kidney disease	□ Skin rashes	□ Difficulty with sleep
□ Anemia	□ Drooling	□ Bladder frequency

Allergies

Allergic to any medications: □ Yes □ No

If yes please list name of medication (s): _____

_____

_____

_____

I certify that the above information is correct to the best of my knowledge:

Patient signature: _____ Date: _____

PALM BEACH NEUROSCIENCE INSTITUTE

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Please write the name of medication and dosage along with how many pills at each time of day.

Patient Name _____

Medication Name & Dosage	12AM	1AM	2AM	3AM	4AM	5AM	6AM	7AM	8AM	9AM	10AM	11AM	12PM	1PM	2PM	3PM	4PM	5PM	6PM	7PM	8PM	9PM	10PM	11PM