



2280 Hemby Lane  
Greenville, North Carolina 27834

# EAST CAROLINA NEUROLOGY

DATE: \_\_\_\_\_ ECN # \_\_\_\_\_  
PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
Home Phone No. \_\_\_\_\_  
Cell Phone No. \_\_\_\_\_

Are you here for test results? Yes \_\_\_ No \_\_\_  
If yes, what tests? \_\_\_\_\_

How is your existing condition? Same \_\_\_ Better \_\_\_ Worse \_\_\_

Do you have any new problems? Yes \_\_\_ No \_\_\_  
If yes, please briefly describe: \_\_\_\_\_

Do you have any of the following problems:

Y N	Y N
Chest Pain	Skin Rash
Shortness of Breath	Visual Disturbance
Stomach Pain	Depression

Are you pregnant or is there a chance you might be pregnant? Yes \_\_\_ No \_\_\_  
Please list any allergies: \_\_\_\_\_

Date of Last Hospitalization _____	Have you seen another doctor since your last visit here? Yes ___ No ___
Reason: _____	Doctor's name: _____ Reason: _____

Do you need a note for work/school? Yes \_\_\_ No \_\_\_  
Do you need any prescriptions refilled? Yes \_\_\_ No \_\_\_  
If yes, please list: \_\_\_\_\_

Are there any changes to your medical, family, or social history since your last visit?  
No \_\_\_ Yes, please list: \_\_\_\_\_

DOCTOR'S USE ONLY

History:

PE:

ROS:

New meds/change in meds:

Plan of treatment:

Vitals

WT \_\_\_\_\_ HT \_\_\_\_\_  
BP \_\_\_\_\_ P \_\_\_\_\_  
Temp \_\_\_\_\_ HC \_\_\_\_\_

PHYSICIANS SIGNATURE \_\_\_\_\_ DATE DICTATED \_\_\_\_\_

