LEXINGTON MEDICAL CENTER
Brain Tumor Program

Lexington Medical Park 3
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LexingtonBrainTumor.com

Patient Information Intake Form – Brain

Date:_____ Name:_____ Date of Birth: _____ Age: _____

Height:_____ Weight: _____ Sex: ☐ Male ☐ Female What Doctor sent you to us: _____

Family Physician:_____ Employer:_____

How did you find out you have this condition?_____

_____

HISTORY OF MEDICAL ILLNESSES: (check yes or no)

Anemia	☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No	Malignancies	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	MVA (motor vehicle accident)	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problem	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Peptic Ulcer	☐ Yes ☐ No
Cerebral Palsy	☐ Yes ☐ No	History of Shortness of Breath	☐ Yes ☐ No	Seasonal Allergies	☐ Yes ☐ No
Chronic Fatigue Disorder	☐ Yes ☐ No	HIV	☐ Yes ☐ No	Severe Anxiety	☐ Yes ☐ No
Circulatory Disease	☐ Yes ☐ No	Hypertension (high blood pressure)	☐ Yes ☐ No	Skin Disorder	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Hypotension (low blood pressure)	☐ Yes ☐ No	Weight Gain	☐ Yes ☐ No
Diabetes Mellitus (type 2)	☐ Yes ☐ No	Hypothyroidism (underactive thyroid)	☐ Yes ☐ No		
Epilepsy	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No		

PREVIOUS IMAGING

Type of Imaging	Month	Year	Location Performed	Comments

We will need a copy of your imaging on a disc in order to review your case.

REVIEW OF NEUROLOGICAL SYMPTOMS

	Yes	No
Headaches	☐	☐
Weakness	☐	☐
Dizziness	☐	☐
Loss of consciousness/Fainting	☐	☐
Other:		

Have you had any surgical procedures related to this condition? ☐ Yes ☐ No

If so:

Type of Procedure	Month	Year