Name MRN DOB	Patient Label **Patient Identification**	VCU Health System MCV Hospitals and Physicians Richmond, Virginia 23298 **Neurology Initial Evaluation History & Physical**

Teaching Physician
Key Findings

Date: ____/____/____ ☐ Admit H&P ☐ Consult Note ☐ Office H&P
Time: ___________ Requested by: ____________________

Vital Signs: BP ______/_______ RR ______ HR ______ T ______ Taken by: _______________
printed name

Pain Assessment: ☐ No pain ☐ Pain reported Pain Score: 1 2 3 4 5 6 7 8 9 10
mild moderate severe very severe worst possible

Pain Type: ______________________ Location: __________________ Quality: _______________________________

Chief Complaint:

History of Present Illness:

Name MRN DOB	Patient Label **Patient Identification**	VCU Health System MCV Hospitals and Physicians Richmond, Virginia 23298 **Neurology Initial Evaluation** **History & Physical**

Date: ___/___/___

Teaching Physician Key Findings

Past Medical History:

Past Surgical History:

Current Medications: **see Interdisciplinary Admission Medication History Form or Ambulatory Care Summary Sheet**

Allergies: NKDA Drug Reaction Drug Reaction
Other Allergies:

Family History: Mother Father Siblings Other

Social History: Single Married Divorced Widowed **Education**: ____________________
Support: ____________________________ Lives alone Direct home support Nearby support
Occupation: ____ Work Retired Disabled
Tobacco: No Yes _____ packs/day _____# of years **ETOH:** No Yes _____ drinks/day
Other Substances: No Yes In Recovery? No Yes

Review of Systems: (describe all positive findings)

	Neg	Pos		Neg	Pos		Neg	Pos
Constitutional	☐	☐	GI	☐	☐	Psych	☐	☐
Eyes	☐	☐	GU	☐	☐	Endocrine	☐	☐
ENT	☐	☐	Musc/Skel	☐	☐	Heme/Lymph	☐	☐
Cardiovasc	☐	☐	Skin/Breast	☐	☐	Allergic/Immuno	☐	☐
Respiratory	☐	☐	Neuro	☐	☐			

Positive Findings:

♦**General Examination:** ☐ Well Developed ☐ Cachectic ☐ Overweight ☐ Underweight
HEENT ☐ NL Abnl:
Neck: ☐ NL Abnl: ♦Carotids ☐ NL Abnl: ☐ Thyromegaly
Lungs: ☐ NL Abnl: ☐ Wheezes ☐ Rhonchi ☐ Rales
♦CV: ☐ NL Abnl: ☐ Murmur ☐ Rub/Gallop ☐ Arrhythmia
ABD: ☐ NL Abnl: ☐ Bowel Sounds ☐ Tenderness ☐ Distended
♦PVS: ☐ NL Abnl: ☐ Pulses ☐ Edema ☐ Cyanosis ☐ Clubbing
Other:

Name MRN DOB	Patient Label Patient Identification	VCU Health System MCV Hospitals and Physicians Richmond, Virginia 23298 **Neurology Initial Evaluation History & Physical**

Date: ___/___/___

Teaching Physician Key Findings

Neurological Exam

♦Mental Status: ☐ Alert, awake ☐ Lethargic ☐ Obtunded ☐ Coma
♦Orientation: ☐ Oriented p p t Abnl:
♦Recent and Remote Memory: ☐ NL Abnl: MMSE ______
♦Attention/Concentration: ☐ NL Abnl:
♦Fund of Knowledge: ☐ NL Abnl:
♦Speech/Language ☐ NL Abnl: ☐ Dysarthria ☐ Aphasia
Other:

Cranial Nerves:

♦2nd ☐ NL Abnl:
♦3rd 4th 6th ☐ NL Abnl:
♦5th ☐ NL Abnl:
♦7th ☐ NL Abnl:
♦8th ☐ NL Abnl:
♦9th ☐ NL Abnl:
♦10th ☐ NL Abnl:
♦11th ☐ NL Abnl:
♦12th ☐ NL Abnl:

Visual Acuity: R _________ L _________

Pupils: Size: R _________ L _________
Light Rxn: R _________ L _________

Visual Fields: ☐ NL Right ☐ NL Left
Abnl:

♦**Ophthalmic:** Fundus ☐ NL Abnl: ☐ R ☐ L
Other:

♦**Motor: Muscle Strength** (Scale of 0-5)

	Upper Extremity								Lower Extremity				
	D	T	B	WE	WF	FE	G	I	HF	KE	KF	DF	PF
Right													
Left													

D=deltoid T=triceps B=biceps WE=wrist extensors WF=wrist flexors FE=finger extensors G=grip I=intrinsics HF=hip flexors KE=knee extensors KF=knee flexors DF=dorsiflexion PF=plantarflexion

Pronator Drift: ☐ Absent Present ☐ R ☐ L

♦**Muscle tone:** Upper: ☐ NL Abnl:
Lower: ☐ NL Abnl:

♦**Sensory** (Light Touch, Pin Prick, Temp, Vibratory, Proprioception) NL=normal ↓=decreased ↑=increased A=absent

LT	PP	Temp	Vib	Prop	**Right** **Left**	LT	PP	Temp	Vib	Prop
					Head					
					Thorax					
					Abdomen					
					Upper Extremity					
					Lower Extremity					

Name MRN DOB	Patient Label **Patient Identification**	VCU Health System MCV Hospitals and Physicians Richmond, Virginia 23298 **Neurology Initial Evaluation History & Physical**

Date: ___/___/___

Teaching Physician Key Findings

Parietal Function:

Extinction ☐ Absent Abnl: Stereognosis ☐ NL Abnl:

Graphesthesia ☐ NL Abnl:

♦**Deep Tendon Reflexes/ Toe Signs:** (scale of 0-4)

	Biceps	Triceps	Brachiorad	Patellar	Achilles	Toes
Right						
Left						

Other reflexes:

♦**Coordination:**

Finger-Nose: ☐ NL Abnl: ☐ R ☐ L

Heel/Knee/Shin: ☐ NL Abnl: ☐ R ☐ L

Rapid Alternating Movements: ☐ NL Abnl: ☐ R ☐ L

♦**Gait and Station:**

Gait and station: ☐ NL Abnl:

Tandem Gait: ☐ NL Abnl:

Romberg: ☐ NL Abnl:

Other:

Data Reviewed:

PT | PTT

____|____|____/ |Mg ________/ MCV |

| | \ | P / \ MCH / \

/ \

Cardiac Panel CK CK-MB Trop I INR

Other Labs: LFT: ALB TP AST ALT ALP

ABG: / / / / /

CXR: EKG:

CT: EEG:

MRI:

Other Studies:

Name **MRN** **DOB**	Patient Label **Patient Identification**	VCU Health System MCV Hospitals and Physicians Richmond, Virginia 23298 **Neurology Initial Evaluation** **History & Physical**

Assessment/Plan: (Problem List)

☐ Head CT ☐ contrast
☐ no contrast
☐ MRI Brain ☐ MRI ____ Spine
☐ DWI ☐ Flair
☐ Gadolinium
☐ MRA
☐ Neck ☐ Circle of Willis
☐ CTA
☐ CXR ☐ ECG ☐ EEG
☐ EMG/Nerve Cond. Studies
☐ Stroke work-up
☐ TEE ☐ TTE
☐ Carotid Dopplers
☐ DVT Prophylaxis
☐ Lumbar Puncture
☐ Seizure precautions
☐ PT consult ☐ OT consult
☐ Speech eval ☐ Swallow eval
☐ Rehab consult
Other:

Teaching Physician's Assessment/Plan:

Resident/NP/PA Signature: ________________________________ **Date:** ____________

Printed Name/ stamp or provider #: ________________________________ **Time:** ____________

☐ **I was present with the resident during the interview & examination of the patient**. I repeated the critical or key portions of the exam. I confirmed/ revised the resident's history, exam, assessment and plan as noted.
☐ **I was NOT present with the resident during the interview & examination of the patient**. I personally interviewed the patient & repeated the critical or key portions of the exam. I confirmed/revised the history, exam, assessment and plan as noted.
☐ **No resident was involved.**

Attending Signature: ________________________________ **Date:** ____________

Baron 1555 Bekenstein 0902 Bell 3077 Burakgazi 4259 **Time:** ____________
Corrrie 4518 DeLorenzo 8882 Felton 2133 Hristova 3382
Miles 1208 Taylor 0344 Towne 2342 Vota 1030 Waterhouse 5628 Zaydan 1771

☐ Additional note dictated. ☐ No note dictated ☐ Letter to follow to ________________________

Name MRN DOB	Patient Label **Patient Identification**	VCU Health System MCV Hospitals and Physicians Richmond, Virginia 23298 **Neurology Initial Evaluation** **History & Physical**

Interdisciplinary Admission Medication History Form

Key for source(s) of information: **P**atien**t** **F**amily **Tr**ansfer records **Rx** vials **Ph**armacy (phone #_____________)
Cerner Info System **O**ther: ___________________

Home/Prior to Admission Prescription Medications and OTC, Herbal & Homeopathic Preparations (*list below*)

Date / Initial	Source of Info	Medication Name	Dose	Route	Frequency	Date/Time Last Dose	Admission Medication Plan: Order	Admission Medication Plan: Modify	Admission Medication Plan: Discontinue
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐

Healthcare provider identification:

Initials ____________ *Print name* _________________________________*Signature* ____________________________

Initials ____________ *Print name* _________________________________*Signature* ____________________________

Initials ____________ *Print name* _________________________________*Signature* ____________________________

Initials ____________ *Print name* _________________________________*Signature* ____________________________

Initials ____________ *Print name* _________________________________*Signature* ____________________________