

**Medical History**

Date: \_\_\_\_\_ My appointment is with: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of primary care physician: \_\_\_\_\_

Reason for seeing the doctor today: \_\_\_\_\_

Previous neurologist: \_\_\_\_\_

Are you right- or left-handed or ambidextrous? (circle one)

Do you have a history of: (circle all that apply and explain below or on the back if needed)

High blood pressure

High cholesterol

Heart disease

Stroke

Migraines

Aneurysm

Diabetes

Cancer

Lung disease

Multiple Sclerosis

Seizures

Neuropathy

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History**

Does anybody in your family have a history of any of the problems listed above? If so, please explain.

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brother(s): \_\_\_\_\_

Sister(s): \_\_\_\_\_

Children: \_\_\_\_\_

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_____	_____
Initials	Date

**Social History**

Occupation: \_\_\_\_\_ If retired, last occupation: \_\_\_\_\_

Do you drink caffeinated beverages? Y / N About \_\_\_\_\_ per day

Do you use tobacco products? Y / N About \_\_\_\_\_ packs per day

Do you drink alcohol? Y / N About \_\_\_\_\_ drinks per \_\_\_\_\_

Do you or have you used street drugs? \_\_\_\_\_

**Medications**

Please list your current medications and doses. Use the back of the page if necessary. If you have a medication list already prepared, attach here.

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**Allergies**

**Drug:** **Reaction:**

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**Symptoms**

Please circle the symptom or symptoms that you currently have or have had in the last six months. If you don't have any symptoms, please check off the appropriate box.

**General**  **No symptoms**

- Fever
- Chills
- Weight loss
- Weight gain
- Fatigue
- Syncope
- Excessive sweating
- Depression
- Anxiety

**Eyes/ears**  **No symptoms**

- Change in vision
- Blurred vision
- Double vision
- Loss of hearing
- Ringing in the ears
- Earaches

**Throat/sinuses**  **No symptoms**

- Sore throat
- Nasal congestion
- Sinus pain
- Nose bleeds

**Neck**  **No symptoms**

- Neck stiffness
- Swollen lymph nodes

**Pulmonary**  **No symptoms**

- Shortness of breath
- Dry cough
- Productive cough

**Pneumonia**

**Cardiac**  **No symptoms**

- Chest pain
- Palpitations
- Hypertension
- Heart murmur

**Vascular/hematologic**  **No symptoms**

- Swollen legs
- Blood clots
- Anemia
- Easy bruising or bleeding
- Transfusions

**Musculoskeletal**  **No symptoms**

- Muscle aches
- Joint pains

**GI**  **No symptoms**

- Swallowing difficulty
- Stomach pain
- Constipation

**Diarrhea**

**Hepatitis**

**Urinary**  **No symptoms**

- Frequency
- Incontinence
- Infections

**Neurological**  **No symptoms**

- Headache
- Seizure
- Stroke
- Weakness
- Tremor
- Imbalance
- Falls

**Other Symptoms**

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