

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: _____

For office use only:	
_____ 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.

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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