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NEUROLOGY

Patient's Personal Health History

Name: ________________________________ DOB: ____________________ Date________________

Medications: Please list all your current prescriptions and non-prescription medications (or attach your list).

☐ No Medications

Medication	Dosage	Medication	Dosage

Do you have any drug allergies (rash/hives/asthma) or **sensitivities**?

Past/Current Medical History

Do you have any current or ongoing medical problems?

Diabetes	___Y___N	High Blood Pressure	___Y___N	Anemia	___Y___N
Heart Disease	___Y___N	Arthritis	___Y___N	Gastrointestinal D/O	___Y___N
Cholesterol	___Y___N	Thyroid Disease	___Y___N	Dementia	___Y___N
Lung Disease	___Y___N	Kidney Disease	___Y___N	Other___________________________	

If you said yes to any of the above please explain for how long? ____

Have you been hospitalized for a serious illness?

Heart Attack	___Y___N	Mental Illness	___Y___N	Meningitis/encephalitis	___Y___N
Stroke	___Y___N	Seizures___Y___N		Other________________________________	

If you said yes to any of the above please indicate date and hospital?

____

____

Have you had any surgeries? If yes, what operation and in what years:

____

____

Serious injuries or accidents (especially to head, spine or limbs):

____

____

Name____________________________ DOB: _____________________________

Family History

	Age	If deceased cause of death:
Father		
Mother		
Sister (#)		
Brother(#)		
Children (#)		

Do you have any family history of the following:

Stroke ___Y___N
Heart attack ___Y___N
Epilepsy ___Y___N
Dementia ___Y___N
Neuropathy ___Y___N
Tremor ___Y___N
Parkinson's ___Y___N
Diabetes ___Y___N
Migraine ___Y___N
Depression ___Y___N
Suicide ___Y___N
Alcoholism ___Y___N
Movement Disorder ___Y___N
Multiple Sclerosis ___Y___N
Other_________________________

If you answered "yes" to any of the above questions please indicated which family member?
____
____

Social History

Martial Status : S M D W
Occupation:_____________________________________
Highest level of education:________________
Do/did you smoke/chew tobacco?__________ If yes,______packs per day for how many_________years.
Do you drink alcohol?____________________ If yes, how much?__________________________________
Do/did you ever use recreation drugs? If yes, what substance?______________________________
Do you use caffeine (coffee/tea/cola)? If yes, how many cups or glasses a day?_________________
Have you been exposed to any serious poisons or toxins? ____
Are you under much stress?___________From your job?__________________From your personal life?_____________
Do you get formal exercise?___Y___N Kinds of exercise____
Daily____Weekly____If weekly, how many times per week?____

Name_____________________________ DOB:______________________________

Review of Systems

Is there a problem with:

General Heath:

Y___N___Weight gain Y___N___Energy level Y___N___bruising
Y___N___Anxiety/depression Y___N___Sleeping pattern Y___N___Swollen nodes/bumps
Y___N___Tolerance of heat/cold Y___N___Skin, nails or hair

Head:

Y___N___Eyes/vision Y___N___Teeth/gums Y___N___Neck Y___N___Arms
Y___N___Nose/sinuses/allergies Y___N___TMJ(jaw joint pain) Y___N___Shoulders
Y___N___Ears/balance/hearing Y___N___Headaches Y___N___Low back Y___N___Legs

Chest:

Y___N___Heart (chest pains/palpitations)Y___N___Lungs (asthma, emphysema, shortness of breath)

Stomach:

Y___N___Heartburn, ulcers Y___N___Sexual function Y___N___Bowels
Y___N___Liver/pancreas/gallbladder Y___N___Bladder

Women: Date of last menstrual period:________________Periods regular?

Preferred Pharmacy 1:
Name:_________________________Address____
City___________________________State_____Zip______Phone_____________________Fax _______________________

Preferred Pharmacy 2:
Name:_________________________Address____
City___________________________State_____Zip______Phone_____________________Fax _______________________