

Neurology Patient History Form

PATIENT DATA	
Name: last _____ first _____	
Date of birth: _____	
MR #.: _____	
Referring MD: _____ Phone# _____	
Person completing form: _____ Date _____	

(If you are here for a return visit, you may complete only side one if other information is unchanged.)

1. Please describe the problem that prompted your appointment and your goals for this visit.

Chief complaint:

2. Please supply the following information:

Age: _____ I am right-handed left handed ambidextrous. I am male female.

Tuberculosis Screen: I have had <input type="checkbox"/> recent fevers <input type="checkbox"/> a history of TB <input type="checkbox"/> a positive PPD test <input type="checkbox"/> Exposure to TB, <input type="checkbox"/> night sweats <input type="checkbox"/> blood-tinged sputum or coughing up blood <input type="checkbox"/> weight loss <input type="checkbox"/> persistent cough greater than 2 weeks.
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3. Please neatly write your current medications (include dose size and number of times a day taken).

Daily Medications:	As needed, Herbal or OTC meds	Allergies:

4. Which symptoms have you experienced in the last month? Please mark with "x" all that apply

REVIEW OF SYSTEMS		
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Back pain	<input type="checkbox"/> Faintness	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Fever	<input type="checkbox"/> Sinus congestion
<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Headache	<input type="checkbox"/> Sleep problems/ <input type="checkbox"/> Snoring
<input type="checkbox"/> Burning with urination	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Teeth or gum problems
<input type="checkbox"/> Chest Pain/ <input type="checkbox"/> Chest Pressure	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Tremors
<input type="checkbox"/> Chills	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Urinary frequency/ <input type="checkbox"/> Incontinence
<input type="checkbox"/> Constipation	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Vision disturbance or change
<input type="checkbox"/> Cough, chronic	<input type="checkbox"/> Muscle pain/ <input type="checkbox"/> Muscle tenderness	<input type="checkbox"/> Weakness
<input type="checkbox"/> Depression	<input type="checkbox"/> Nausea/ <input type="checkbox"/> Vomiting	<input type="checkbox"/> Weight gain
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Weight loss, trying; <input type="checkbox"/> Not trying
<input type="checkbox"/> Difficulty with swallowing	<input type="checkbox"/> Panic attack	<input type="checkbox"/> Other:
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Rash	<input type="checkbox"/> Other:

5. If you have headaches, back pain or other pain, please complete the following section

Check here if you do not have a problem with pain.

PAIN ASSESSMENT	
Location of pain: _____	Radiation (where does pain move): _____
Duration (how long does pain last): _____	
Severity – How bad is the pain on a 1-10 scale, with 10 the worst pain you can imagine: _____ /10	
Timing – pain occurs most: <input type="checkbox"/> morning <input type="checkbox"/> afternoon <input type="checkbox"/> evening <input type="checkbox"/> night <input type="checkbox"/> any time <input type="checkbox"/> wakes me from sleep	
Quality: <input type="checkbox"/> dull <input type="checkbox"/> stabbing <input type="checkbox"/> sharp <input type="checkbox"/> burning <input type="checkbox"/> throbbing <input type="checkbox"/> other (describe): _____	
Recent change – pain is: <input type="checkbox"/> worse <input type="checkbox"/> better <input type="checkbox"/> more frequent <input type="checkbox"/> less frequent <input type="checkbox"/> no recent change	
<input type="checkbox"/> I am taking pain meds <input type="checkbox"/> I am using a pain control strategy. Current therapy is <input type="checkbox"/> working well <input type="checkbox"/> not working	

6. MEDICAL HISTORY (Mark and X and write the year this was diagnosed)		
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Headaches	<input type="checkbox"/> Seizures, epilepsy
<input type="checkbox"/> Angina	<input type="checkbox"/> Hypertension (High blood pressure)	<input type="checkbox"/> Seizures, nonepileptic
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Shingles
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Infertility	<input type="checkbox"/> Skin cancer
<input type="checkbox"/> Bowel problems	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Systemic Lupus Erythematosus
<input type="checkbox"/> Cancer: Type	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Cardiac Arrhythmias (A-fib)	<input type="checkbox"/> Lipid disorders, high cholesterol	<input type="checkbox"/> Stroke <input type="checkbox"/> TIA (mini-stroke)
<input type="checkbox"/> Cardiac disease (heart disease)	<input type="checkbox"/> Liver conditions	<input type="checkbox"/> Syncope (fainting)
<input type="checkbox"/> COPD, emphysema	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Tremor
<input type="checkbox"/> Dementia	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Depression	<input type="checkbox"/> Myopathy (muscle disease)	<input type="checkbox"/> Uterine: <input type="checkbox"/> Endometriosis, <input type="checkbox"/> Fibroids
<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> trauma/accident
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Other:
<input type="checkbox"/> Gastritis or GERD	<input type="checkbox"/> Peripheral vascular disease	<input type="checkbox"/> Other:

7. PRIOR SURGICAL PROCEDURES (Mark an X and write the year of the surgery)	
<input type="checkbox"/> Back surgery	<input type="checkbox"/> Laparoscopy
<input type="checkbox"/> Brain surgery	<input type="checkbox"/> Mastectomy
<input type="checkbox"/> CABG, Coronary artery bypass (Heart bypass)	<input type="checkbox"/> Neck surgery
<input type="checkbox"/> Carotid endarterectomy: <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Sinus surgery
<input type="checkbox"/> Cataract surgery	<input type="checkbox"/> Spine surgery
<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> Tonsillectomy and adenoids
<input type="checkbox"/> C-section	<input type="checkbox"/> Tubal ligation
<input type="checkbox"/> Hysterectomy/ <input type="checkbox"/> Ovaries removed also	<input type="checkbox"/> TURP, prostate surgery
<input type="checkbox"/> Hip surgery / <input type="checkbox"/> Knee surgery	Other:

8. Which of these tests have you had? Please mark appropriate boxes with an "X".

MEDICAL EVALUATIONS (write the place and date of the test)		
<input type="checkbox"/> MRI	<input type="checkbox"/> EEG	<input type="checkbox"/> Carotid Doppler
<input type="checkbox"/> CT	<input type="checkbox"/> EMG/NCS	<input type="checkbox"/> Echocardiograph

9. Please mark appropriate boxes with an "X"

SOCIAL HISTORY	
Occupation:	I am <input type="checkbox"/> DISABLED <input type="checkbox"/> RETIRED since: _____
Marital Status:	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED
Habits:	<input type="checkbox"/> caffeine: ___ drinks/day <input type="checkbox"/> smoking: ___ cig/day ___ years smoked <input type="checkbox"/> alcohol: ___ drinks/day <input type="checkbox"/> drug use
Education:	<input type="checkbox"/> some High School <input type="checkbox"/> HS Diploma <input type="checkbox"/> College ___ yrs <input type="checkbox"/> Graduate/Professional School ___ yrs
ABUSE SCREEN:	<input type="checkbox"/> Have you suffered emotional, physical or sexual abuse?

10. Which of these diseases run in your family? Please mark with "x" all that apply.

FAMILY HISTORY (list the relative involved next to the diagnosis)		
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Domestic violence	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Brain Aneurysms	<input type="checkbox"/> Elevated cholesterol	<input type="checkbox"/> Parkinson's
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Depression	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Seizures
<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Migraine	<input type="checkbox"/> Stroke
Father: age state of health	Mother: age state of health	
Siblings:		

Reviewed by MD _____ Date _____