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Neurology Clinic Patient Information Form

*This form will help the doctor obtain information relevant to your care. Please fill out **both sides** as best you can.*

Patient's Name: ______________________________

Medical Record #: ________________ Date: ________

Age: _____ Referring Physician: ____________________

Our doctors will send a report to your referring physician. Please indicate if you want a copy sent to someone else:

☐ Other Physician: ____________________________

Address: ____________________________

City: ______________ State: ______ Zip: ________

☐ Yourself

☐ Other: ____________________________

Please state the main reason for this visit. *Just state your main symptom(s) or concerns, for example "headache" or "trouble walking" or "concern about abnormal MRI.". Do not include details of your history or testing. You will have ample opportunity to give the doctor the complete story. On the reverse side of this form you can check off specific symptoms.*

____

Medical History: *Please check any diseases that you have had in the past or have now and the year of onset:*

Disorder	*Onset*	*Disorder*	*Onset*	*Disorder*	*Onset*	*Disorder*	*Onset*
☐ Heart Disease	____	☐ High blood pres.	____	☐ Lung disease	____	☐ Thyroid disease	____
☐ Atrial Fibrillation	____	☐ High cholesterol	____	☐ Asthma	____	☐ Migraine	____
☐ Blood clots	____	☐ Diabetes	____	☐ Kidney failure	____	☐ Sleep disorder	____
☐ Stroke	____	On insulin? ☐ yes ☐ no		Trauma		☐ Miscarriages	____
☐ Epilepsy	____	☐ Cancer:		☐ Head	____	☐ Reflux (GERD)	____
☐ Liver disease	____	*Location*	*Year*	☐ Neck	____	☐ Irritable bowel	____
		________	____	☐ Back	____	☐ Fibromyalgia	____
		________	____	☐ Other	____		

Other Medical History: ____

Surgical History: *Please check surgeries you have had and indicate year.*

Surgery	*Date*	*Surgery*	*Date*	*Surgery*	*Date*	*Surgery*	*Date*
☐ Heart	____	☐ Colon polyp	____	☐ GI bypass/stapling (bariatric surg.)	____	☐ Hip replacement	____
☐ Bypass graft	____	☐ C-section	____	☐ Hernia	____	☐ Knee replacemnt	____
☐ Stent	____	☐ Gall bladder	____	☐ Vasectomy	____	☐ Cataract	____
☐ Cancer *(fill in type)*		☐ Breast lump	____	☐ Bladder	____	*Other surgeries:*	
☐ ________	____	☐ Appendix	____	☐ Brain	____	☐ ________	____
☐ ________	____	☐ Tonsils	____	☐ Neck	____	☐ ________	____
☐ ________	____	☐ Hysterectomy	____			☐ ________	____

Social History:

Marital status:
☐ Single
☐ Married
☐ Divorced

You live with:
☐ Alone
☐ Spouse
☐ Children
☐ Partner
☐ Other: __________

You Live at:
☐ Your Home
☐ Relative's home
☐ Assisted Living Facility
☐ Nursing Home
☐ Other: ________

Education completed:
☐ Grade school
☐ High school
☐ College
☐ Advanced degree

Current or most recent occuption:
____
☐ Retired — year: ______
☐ Disabled — year: ______

Do you use alcohol?
☐ Never
☐ Quit: When?: ________
☐ Yes: Amount: ________

Smoking history:
☐ Never smoked
☐ Currently smoke: _____ *packs/day*
☐ Quit smoking in ________
Lifetime cigarette use:
_____Packs/day for _____ years.

Please continue on reverse side

Have you ever had: ☐ Blood Transfusion; ☐ Hepatitis: type ☐ A; ☐ B; or ☐ C; ☐ HIV (AIDS); ☐ Substance abuse

Family History

	Alive (give age)	*Died (at age)*	*of (cause of death)*
Mother			
Father			

Siblings (give numbers):

Sisters: ____________ Brothers: ____________

Children (give numbers):

Girls: ____________ Boys: ____________

For each of the disorders listed below, indicate in the column titled ***"Rel"*** which family member(s) had the illness, using the abbreviations listed.

Relationship Abbreviations:

M	mother
F	father
B	brother
S	sister
C	child
GP	grandparent
O	other

Rel.	***disease***	***Rel.***	***disease***
	Any neurologic dis.		High blood press.
	Dementia		Diabetes
	Neuropathy		Heart disease
	Epilepsy or seizure		Cancer
	Muscle problem		Lupus or Rheumatoid Arthritis
	Stroke		Thyroid disease
	Migraine		Other:

Allergies: Please list any medications to which you are allergic, and state the nature of the reaction:

Medication	*Reaction*

Medications: List below, or provide the doctor or nurse with a list.

Medication	*Dose*	*Frequency*	*Medication*	*Dose*	*Frequency*

Review of symptoms: Please check any symptom that you have recently experienced or have concerns about.

- ☐ Headache
- ☐ Neck pain
- ☐ Back pain
- ☐ Pain in limbs
- ☐ Joint pain
- ☐ Stomach pain
- ☐ Other pain: __________
- ☐ Weakness
- ☐ Muscle cramps
- ☐ Numbness or tingling
- ☐ Trouble seeing
- ☐ Trouble hearing
- ☐ Trouble with speech

- ☐ Trouble sleeping
- ☐ Daytime drowsiness
- ☐ Fainting or blackouts
- ☐ Seizures or epilepsy
- ☐ Memory loss
- ☐ Hallucinations
- ☐ Confusion
- ☐ Nervousness
- ☐ Irritability
- ☐ Anxiety
- ☐ Depression or sadness
- ☐ Fatigue
- ☐ Trouble swallowing

- ☐ Poor appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody or tarry stools
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Ankle swelling
- ☐ Trouble sleeping flat
- ☐ Dizziness

- ☐ Over 10 lbs weight loss
- ☐ Over 10 lbs weight gain
- ☐ Pain on urination
- ☐ Trouble starting urine
- ☐ Trouble holding urine
- ☐ Blood in urine
- ☐ Urinating often
- ☐ Waking to urinate
  ___ times per night
- ☐ Sexual dysfunction
- ☐ Fever or chills
- ☐ Unusual thirst
- ☐ Vertigo (spinning)

- ☐ Irregular periods
- ☐ Heavy periods
- ☐ Lumps in breast
- ☐ Breast discharge
- ☐ Rash
- ☐ Easy bruising
- ☐ Growing moles
- ☐ Arthritis

List other symptoms:

____

:____________________

____

____

Thank you for your assistance. Patient's signature: ______________________________ Date: ____________

I reviewed this history form with the patient: Physician's Signature: ______________________________ Date: ____________