# 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 ☐recent fevers ☐ a history of TB ☐a positive PPD test ☐Exposure to TB, ☐night sweats ☐blood-tinged sputum or coughing up blood ☐weight loss ☐persistent cough greater than 2 weeks.

**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:*** |
|---|---|---|
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| | | |

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

| ***REVIEW OF SYSTEMS*** | | |
|---|---|---|
| ☐Abdominal pain | ☐Fatigue | ☐Ringing in ears |
| ☐Back pain | ☐Faintness | ☐Shortness of breath |
| ☐Blood in urine | ☐Fever | ☐Sinus congestion |
| ☐Bruise easily | ☐Headache | ☐Sleep problems/☐Snoring |
| ☐Burning with urination | ☐Heart palpitations | ☐Teeth or gum problems |
| ☐Chest Pain/ ☐Chest Pressure | ☐Heartburn | ☐Tremors |
| ☐Chills | ☐Joint pain | ☐Urinary frequency/☐Incontinence |
| ☐Constipation | ☐Memory loss | ☐Vision disturbance or change |
| ☐Cough, chronic | ☐Muscle pain/☐Muscle tenderness | ☐Weakness |
| ☐Depression | ☐Nausea/ ☐Vomiting | ☐Weight gain |
| ☐Diarrhea | ☐Neck pain | ☐Weight loss, trying; ☐ Not trying |
| ☐Difficulty with swallowing | ☐Panic attack | ☐Other: |
| ☐Dizziness | ☐Rash | ☐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:*** ☐ morning ☐ afternoon ☐ evening ☐ night ☐ any time ☐ wakes me from sleep |
| ***Quality:*** ☐ dull ☐ stabbing ☐ sharp ☐ burning ☐ throbbing ☐ other (describe): |
| ***Recent change – pain is:*** ☐worse ☐better ☐more frequent ☐less frequent ☐no recent change |
| ☐ I am taking pain meds ☐ I am using a pain control strategy. **Current therapy is** ☐ working well ☐ not working |

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

| *7. PRIOR SURGICAL PROCEDURES (Mark an X and write the year of the surgery)* | |
|---|---|
| ☐Back surgery | ☐Laparoscopy |
| ☐Brain surgery | ☐Mastectomy |
| ☐CABG, Coronary artery bypass (Heart bypass) | ☐Neck surgery |
| ☐Carotid endarterectomy: ☐Right ☐Left | ☐Sinus surgery |
| ☐Cataract surgery | ☐Spine surgery |
| ☐Cholecystectomy | ☐Tonsillectomy and adenoids |
| ☐C-section | ☐Tubal ligation |
| ☐Hysterectomy/ ☐ Ovaries removed also | ☐TURP, prostate surgery |
| ☐Hip surgery / ☐ 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)* | | |
|---|---|---|
| ☐MRI | ☐EEG | ☐Carotid Doppler |
| ☐CT | ☐EMG/NCS | ☐Echocardiograph |

**9. Please mark appropriate boxes with an "X"**

| *SOCIAL HISTORY* |
|---|
| **Occupation:** I am ☐DISABLED ☐RETIRED since: _____ |
| **Marital Status:** ☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED ☐WIDOWED |
| **Habits:** ☐caffeine: ___ drinks/day ☐smoking: ___ cig/day _____years smoked ☐alcohol: ___drinks/day ☐drug use |
| **Education:** ☐some High School ☐HS Diploma ☐College __ yrs ☐Graduate/Professional School ___yrs |
| **ABUSE SCREEN:** ☒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)* | | |
|---|---|---|
| ☐Alcoholism | ☐Domestic violence | ☐Multiple sclerosis |
| ☐Alzheimer's | ☐Drug abuse | ☐Neuropathy |
| ☐Brain Aneurysms | ☐Elevated cholesterol | ☐Parkinson's |
| ☐Cancer | ☐Heart disease | ☐Schizophrenia |
| ☐Depression | ☐High blood pressure | ☐Seizures |
| ☐Diabetes mellitus | ☐Migraine | ☐Stroke |
| Father: age state of health | | Mother: age state of health |
| Siblings: | | |

Reviewed by MD_____ Date _____