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:***

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 _____