Health History - Neurology

Name: _____ **DOB:** _____
Preferred Name (Nickname): _____
Pharmacy Name: _____ **Pharmacy Address:** _____
PCP/Referring Provider Name: _____
List of all doctors you see (Care Team): _____

Reason for today's visit: _____
When did your symptoms begin? _____
What triggers your symptoms? _____
What makes your symptoms better? _____ _____
Grade your pain 0-10 (0= no pain and 10=worst pain): 10 = worst pain _____
What treatment have you had for your symptoms? _____
Have you experienced this problem before? _____
Is your problem getting: Worse ☐ Better ☐ The same ☐
What makes your symptoms worse? _____
Location of the symptoms? _____
How long do your symptoms last? _____

ALLERGIES List all allergies to medications or foods and your reaction:

ALLERGY	REACTION

MEDICATIONS Please list all medicines you are currently taking (include over the counter such as vitamins):

NAME OF MEDICATION	DOSAGE	HOW OFTEN PER DAY

FAMILY HISTORY Please list any relative with the following medical problems and their relationship to you:

	Relation		Relation
☐ ADHD (Attention deficit hyperactivity disorder)		☐ High blood pressure	
☐ Aneurysm		☐ Mental disorder	
☐ Bleeding Disorder/Thrombosis		☐ Multiple sclerosis	
☐ Dementia		☐ Parkinson's disease	
☐ Depressive disorder		☐ Seizure disorder	
☐ Family history of cancer		☐ Sleep apnea	
☐ Glaucoma		☐ Stroke	
☐ Headaches		☐ Substance abuse	
☐ Heart Attack (MI)		☐ Vertigo	
☐ Heart disease			

SOCIAL HISTORY

Tobacco Use	Do you currently use tobacco? ☐ Yes ☐ No Did you use tobacco in your past? ☐ Yes ☐ No How Long? _____ Year Quit: _____ ☐ Cigarettes-___/day ☐ Chew-___/day ☐ Cigars-___/day
Alcohol Intake	☐ None ☐ Occasional ☐ Moderate ☐ Heavy How many days in the past year have you had a heavy drinking consumption (4+ female, 5+ male)? ____
Caffeine Intake	☐ None ☐ Occasional ☐ Moderate ☐ Heavy # of cups/cans per day _____
Illicit Drug Use/Abuse	☐ Yes ☐ No Drug Abuse Type: _____ Illicit drug years of use: _____
Employment	Occupation: Employer:
Live alone or with others?	☐ Alone ☐ With others
Number of Children	
Do you have trouble sleeping ?	night ?
Exercise Level	☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Advance directive?	☐ Yes ☐ No

PAST SURGICAL HISTORY Have you ever had the following:

	Year		Year
☐ Abdominal Surgery		☐ Fracture Surgery	
☐ Back Surgery		☐ Heart Surgery	
☐ Cancer Surgery		☐ Neck Surgery	
☐ Carpal Tunnel Surgery		☐ Neurosurgery	
☐ ENT Surgery		☐ Vascular Surgery	
☐ Eye Surgery		☐ Other Surgeries:	

Any other Medical/Surgical history/conditions, please inform the nurse.

PAST MEDICAL HISTORY Have you ever been told you had one of the following? *Please check Yes, if you have now or have had in the past.*

	Yes	No		Yes	No
ADD/ADHD	☐	☐	Heart Attack (MI)	☐	☐
AIDS	☐	☐	High Blood Pressure	☐	☐
Anemia	☐	☐	High Cholesterol	☐	☐
Anxiety	☐	☐	HIV	☐	☐
Arthritis	☐	☐	Kidney Disease/Stones	☐	☐
Asthma	☐	☐	Liver Disease/Hepatitis	☐	☐
Atrial Fibrillation	☐	☐	Mental Illness	☐	☐
Autoimmune Disease	☐	☐	Movement Disorder	☐	☐
Bleeding Disorder/DVT	☐	☐	Multiple Sclerosis	☐	☐
Congestive Heart Failure	☐	☐	Neuropathy	☐	☐
COPD	☐	☐	Osteoporosis	☐	☐
Coronary Artery Disease	☐	☐	Overweight/Obesity	☐	☐
Dementia	☐	☐	Prostate Disorder	☐	☐
Depression	☐	☐	Seizure	☐	☐
Diabetes Type 1	☐	☐	Stomach /Digestive Disease	☐	☐
Diabetes Type 2	☐	☐	Stroke/TIA	☐	☐
Eye/Vision Problems	☐	☐	Syncope or Passing Out	☐	☐
Fibromyalgia/Pain Disorder	☐	☐	Thyroid Disease	☐	☐
Gastritis/Ulcer	☐	☐	Tuberculosis (Or Positive TB Test)	☐	☐
Glaucoma	☐	☐	Urinary Problems	☐	☐
Headaches/Migraines	☐	☐	Other:		

Review of Systems

Check all that apply:

Constitutional

- ☐ Yes ☐ No Significant weight gain
- ☐ Yes ☐ No Significant weight loss
- ☐ Yes ☐ No Fever
- ☐ Yes ☐ No Sleep Difficulty
- ☐ Yes ☐ No Fatigue

Hand Dominance

- ☐ Yes ☐ No Right Hand
- ☐ Yes ☐ No Left Hand
- ☐ Yes ☐ No Ambidextrous

ENMT

Ears

- ☐ Yes ☐ No Ear Pain
- ☐ Yes ☐ No Loss of Hearing
- ☐ Yes ☐ No Ringing in Ears

Nose

- ☐ Yes ☐ No Sinus Congestion
- ☐ Yes ☐ No Frequent Nosebleeds

Mouth/Throat

- ☐ Yes ☐ No Sore Throat
- ☐ Yes ☐ No Difficulty Swallowing

Cardiovascular

- ☐ Yes ☐ No Chest Pain
- ☐ Yes ☐ No Palpitations
- ☐ Yes ☐ No Swelling of Feet

Respiratory

- ☐ Yes ☐ No Cough
- ☐ Yes ☐ No Wheezing
- ☐ Yes ☐ No Shortness of Breath
- ☐ Yes ☐ No Coughing up Blood
- ☐ Yes ☐ No Asthma

Gastrointestinal

- ☐ Yes ☐ No Abdominal Pain
- ☐ Yes ☐ No Heart Burn
- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Vomiting
- ☐ Yes ☐ No Change in Bowel Habit
- ☐ Yes ☐ No Diarrhea
- ☐ Yes ☐ No Rectal Bleeding
- ☐ Yes ☐ No Blood in Stool

Genitourinary

- ☐ Yes ☐ No Difficulty/Painful Urination
- ☐ Yes ☐ No Change in Frequency
- ☐ Yes ☐ No Incontinence
- ☐ Yes ☐ No Good Urinary Stream
- ☐ Yes ☐ No Blood in Urine
- ☐ Yes ☐ No Genital Lesion

Musculoskeletal

- ☐ Yes ☐ No Joint Pain
- ☐ Yes ☐ No Muscle Aches
- ☐ Yes ☐ No Back Pain
- ☐ Yes ☐ No Neck Pain
- ☐ Yes ☐ No Joint Stiffness

Dermatology

- ☐ Yes ☐ No Rashes
- ☐ Yes ☐ No Itching
- ☐ Yes ☐ No Change in Hair
- ☐ Yes ☐ No Change in Nails
- ☐ Yes ☐ No Change in Moles

Neurologic

- ☐ Yes ☐ No Disorientation
- ☐ Yes ☐ No Memory Loss
- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Fainting
- ☐ Yes ☐ No Loss of Conciousness
- ☐ Yes ☐ No Headaches
- ☐ Yes ☐ No Speech Difficulty
- ☐ Yes ☐ No Tremors
- ☐ Yes ☐ No Difficulty Balancing
- ☐ Yes ☐ No Double Vision
- ☐ Yes ☐ No Blurred Vision
- ☐ Yes ☐ No Numbness
- ☐ Yes ☐ No Tingling
- ☐ Yes ☐ No Generalized Weakness
- ☐ Yes ☐ No Muscle Twitching
- ☐ Yes ☐ No Walking Difficulty
- ☐ Yes ☐ No Convulsions

Psychiatric

- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Nervousness
- ☐ Yes ☐ No Hallucinations
- ☐ Yes ☐ No Paranoia
- ☐ Yes ☐ No Anxiety

Endocrine

- ☐ Yes ☐ No Fatigue
- ☐ Yes ☐ No Excessive Urination
- ☐ Yes ☐ No Excessive Thirst
- ☐ Yes ☐ No Excessive Hunger
- ☐ Yes ☐ No Sweats
- ☐ Yes ☐ No Hair/Skin Changes
- ☐ Yes ☐ No Change in Libido

Hematologic/Lymphatic

- ☐ Yes ☐ No Swollen Glands
- ☐ Yes ☐ No Bruising
- ☐ Yes ☐ No Excessive Bleeding
- ☐ Yes ☐ No Easy Bleeding
- ☐ Yes ☐ No Past Blood Transfusion