



**MEDICAL HISTORY**

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

In order to be able to help with your problem, we need a complete detailed history; please complete this form fully. If you need more space please write on the back of the pages as needed.

CHIEF COMPLAINT: (in a few words summarize your problem): \_\_\_\_\_

HISTORY OF PRESENT ILLNESS: (give a detailed account of your problem starting from the onset; describe contributing factors and treatment if necessary):

SYSTEM REVIEW: (problems you have with other body parts or functions may be important to your neurologic problem; please describe below any problems you may have with any of the following):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> general wellbeing      | <input type="checkbox"/> ulcers                 | <input type="checkbox"/> chest pain             |
| <input type="checkbox"/> weight loss            | <input type="checkbox"/> indigestion            | <input type="checkbox"/> abnormal heart beat    |
| <input type="checkbox"/> memory                 | <input type="checkbox"/> diarrhea               | <input type="checkbox"/> palpitations           |
| <input type="checkbox"/> vision                 | <input type="checkbox"/> blood in stool         | <input type="checkbox"/> anxiety                |
| <input type="checkbox"/> hearing                | <input type="checkbox"/> bloating               | <input type="checkbox"/> nervousness            |
| <input type="checkbox"/> voice                  | <input type="checkbox"/> hernia                 | <input type="checkbox"/> arthritis              |
| <input type="checkbox"/> swallow                | <input type="checkbox"/> joint pain or swelling | <input type="checkbox"/> sleep disturbance      |
| <input type="checkbox"/> abnormal neck swelling | <input type="checkbox"/> skin rashes            | <input type="checkbox"/> trouble with urination |
| <input type="checkbox"/> shortness of breath    | <input type="checkbox"/> sexual dysfunction     | <input type="checkbox"/> stroke                 |
| <input type="checkbox"/> constipation           | <input type="checkbox"/> seizures               | <input type="checkbox"/> infections             |
| <input type="checkbox"/> depression             | <input type="checkbox"/> loss of appetite       | <input type="checkbox"/> other _____            |
| <input type="checkbox"/> ankle swelling         | <input type="checkbox"/> bleeding problems      | _____   |

**SOCIAL HISTORY:**

Occupation \_\_\_\_\_

Marital status \_\_\_\_\_

Tobacco use: yes \_\_\_ no \_\_\_ type \_\_\_ how long \_\_\_ how long ago did you stop \_\_\_

Alcohol use: yes \_\_\_ no \_\_\_ how much \_\_\_\_\_

Have you traveled outside the region: where \_\_\_\_\_ when \_\_\_\_\_

FAMILY HISTORY: (do any of your blood kin relatives have a history of any of the following conditions and if so who?):

- |                             |                               |
|-----------------------------|-------------------------------|
| _____ High blood pressure   | _____ Tuberculosis            |
| _____ Heart attack          | _____ Diabetes mellitus       |
| _____ Heart bypass surgery  | _____ Cancer                  |
| _____ Heart Failure         | _____ Neurofibromatosis       |
| _____ Emphysema             | _____ Stroke                  |
| _____ Asthma                | _____ Aneurysm                |
| _____ Blood vessel blockage | _____ Arthritis               |
| _____ Seizures              | _____ Other                   |
| _____ Blood disorder        | _____ Blood/Clotting disorder |

PAST HISTORY: (do you have or have you had any of the following and when?):

_____ High blood pressure	_____ Tuberculosis
_____ Heart attack	_____ Diabetes mellitus
_____ Heart bypass surgery	_____ Cancer
_____ Heart Failure	_____ Neurofibromatosis
_____ Emphysema	_____ Stroke
_____ Asthma	_____ Aneurysm
_____ Blood vessel blockage	_____ Arthritis
_____ Seizures	_____ Spinal disorders
_____ Immune disorders	_____ Other _____
_____ Blood disorders	_____ Blood/Clotting disorders

List SURGICAL PROCEDURES you have had (include invasive procedures such as angioplasty, colon polyps, cystoscopy, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List names and dosages of all MEDICATIONS you take including non-prescription medicines:

Name	Strength	How Often

Are you ALLERGIC to any medications or drugs? \_\_\_ No \_\_\_ Yes (if yes list the drug name and type of reaction below):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything else about you that might affect your health or your response to medical treatment?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What doctors have you seen for this problem?

\_\_\_\_\_  
\_\_\_\_\_

What tests have you had for this problem?

\_\_\_\_\_  
\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_