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NEW PATIENT HEALTH HISTORY

DATE OF VISIT: _____ **PATIENT NAME:** _____

DOB: _____ **AGE:** _____ **HEIGHT:** _____ **WEIGHT:** _____

GENDER: __ **FEMALE** __ **MALE** **HAND DOMINANACE:** __ **RIGHT** __ **LEFT** __ **AMBIDEXTROUS**

PRIMARY CARE PROVIDER: _____

OTHER PROVIDERS: _____

What is your major neurological complaint or why did you ask your doctor to see a neurologist?

_____

_____

_____

_____

_____

CURRENT MEDICATIONS:

MEDICATION NAME	DOSE/FREQUENCY

Name and address of current pharmacy: _____

_____

NEW PATIENT HEALTH HISTORY CONTINUED

DATE OF VISIT: _____ PATIENT NAME: _____ DOB: _____

MEDICATION ALLERGIES:

WHAT MEDICATIONS HAVE YOU TRIED FOR THIS IN THE PAST FOR THIS PROBLEM?

MEDICATION NAME	STRENGTH	REASON FOR STOPPING

SURGICAL HISTORY

SURGERY TYPE	DOCTOR/ FACILITY	DATE

SOCIAL HISTORY

Do you smoke tobacco? ___ YES (___/ DAY Type: _____) QUIT (How long ago? _____) ____NEVER

Do you drink alcohol? ___ YES (How much/ often? _____) ____NO

Do you use illicit drugs? ___ YES ___ NO If yes please explain: _____

Do you drink caffeine? ___ YES (How much/ often? _____) ____NO

What is your occupation? _____ Marital Status: _____ How many children? _____

PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

ARTHRITITS: RHEUMATOID/SARCOID/ PSORIASIS _____YES _____NO	HEADACHE OR MIGRAINE: _____YES _____NO	STROKE: _____YES _____NO
CANCER: TYPE: _____ _____YES _____NO	HIGH BLOOD PRESSURE: _____YES _____NO	THYROID CONDITION: _____YES _____NO
DEMENTIA: _____YES _____NO	HIGH CHOLESTEROL: _____YES _____NO	MULTIPLE SCLEROSIS: _____YES _____NO
DIABETES: _____YES _____NO	NEUROPATHY: _____YES _____NO	ULCERATIVE COLITIS/ CROHN'S DISEASE: _____YES _____NO
EPILEPSY: _____YES _____NO	PARKINSON'S DISEASE: _____YES _____NO	OTHER SIGNIFICANT FAMILY HISTORY:

FAMILY MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

ARTHRITITS: RHEUMATOID/SARCOID/ PSORIASIS __MOTHER___FATHER__SIBLING	HEADACHE OR MIGRAINE: __MOTHER___FATHER___SIBLING	STROKE: __MOTHER___FATHER___SIBLING
CANCER: TYPE: _____ __MOTHER___FATHER___SIBLING	HIGH BLOOD PRESSURE: __MOTHER___FATHER___SIBLING	THYROID CONDITION: __MOTHER___FATHER___SIBLING
DEMENTIA: __MOTHER___FATHER___SIBLING	HIGH CHOLESTEROL: __MOTHER___FATHER___SIBLING	MULTIPLE SCLEROSIS: __MOTHER___FATHER___SIBLING
DIABETES: __MOTHER___FATHER___SIBLING	NEUROPATHY: __MOTHER___FATHER___SIBLING	ULCERATIVE COLITIS/ CROHN'S DISEASE: __MOTHER___FATHER__SIBLING
EPILEPSY: __MOTHER___FATHER___SIBLING	PARKINSON'S DISEASE: __MOTHER___FATHER__SIBLING	OTHER SIGNIFICANT FAMILY HISTORY:

REVIEW OF SYSTEMS

PLEASE CIRCLE ALL THAT APPLY

CONSTITUTIONAL -Fever -Night sweats -Lack of energy -Weight gain (___lbs.) -Weight loss (___lbs.)	**GASTROINTESTINAL** -Abdominal pain -Vomiting -Vomiting blood -Nausea -Diarrhea -Constipation -Bowel loss of control	**INTEGUMENTARY** -Rash -Itching -Dry skin -Growths/ lesions
EYES -Dry eyes -Irritation -Vision changes -Ptosis (drooping) -Abnormal eye	**GENITOURINARY** -Urinary loss of control -Difficulty urinating -Increased frequency -Hematuria (blood in urine) -Nocturia (excessive night time urination)	**PSYCHIATRIC** -Depression -Sleep disturbances -Restless legs -Anxiety -Hallucinations
E.N.M.T. -Ear pain -Sore throat -Loss of smell -Facial swelling -Mouth ulcers -Trouble swallowing -Hearing loss -Sinus problems	**MUSCULOSKELETAL** -Muscle aches -Muscle weakness -Joint pain -Back pain -Neck pain -Difficulty Walking	**ENDOCRINE** -Fatigue -Increased thirst -Hair loss -Cold intolerance -Heat intolerance
CARDIOVASCULAR -Angina (chest pain) -Swelling of extremities -Palpitations -Known heart murmur -Lightheadedness upon standing	**NEUROLOGIC** -Weakness -Numbness/Tingling -Seizures or Tremor -Memory loss - Word finding difficulty -Imbalance -Incoordination -Dizziness/light headedness -Jerking -Fainting -Confusion -Blurred Vision -Slurred speech -Migraines - Headaches -Difficulty Walking	**HEMATOLOGIC/ LYMPHATIC** -Swollen glands -Easy bruising -Excessive bleeding -Blood clots
RESPIRATORY -Frequent cough -Wheezing -Shortness of breath -Coughing up blood -Sleep apnea -Snoring	**ALLEGIC/ IMMUNOLOGIC** -Allergy symptoms -Sinus pressure -Itching -Hives	**OTHER** _____ _____ _____ _____ _____

PATIENT SIGNATURE: _____ **DATE:** _____