

MEDICAL HISTORY FORM



NAME: _____ AGE: _____ DATE: _____

CHIEF COMPLAINT TO NEUROLOGIST: _____

DATE SYMPTOMS STARTED _____ ALLERGIES _____

TESTS	DATE	PART OF BODY TESTED
EEG	_____	_____
MRI	_____	_____
PET SCAN	_____	_____
CT	_____	_____

MEDICATIONS	DOSE	FREQUENCY	REASON USED	START DATE (est)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

OPERATIONS	DATE	MAJOR ILLNESSES	ONSET
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CIRCLE IF YOU HAVE

GENERAL	EYE	SKIN	EAR NOSE THROAT	GENITO URINARY
Fever	Eye pain	Rash	Hearing loss	Hematuria
Malaise	Glaucoma	Psoriasis	Tinnitus	Dysuria
Weight gain	Blurred vision	Melanoma	Hoarse voice	Incontinence
Weight loss	Double vision	Acne	Vertigo	Kidney stones
Anemia	Temp loss of vision			Bladder infections
CARDIOVASC	RESPIRATORY	GASTROINTEST	MUSCLE SKELETAL	NEUROLOGICAL
Chest pain	Asthma	Heartburn	Neck pain	Stroke
Palpitation	Shortness of breath	Nausea	Back pain	Seizures
Pacemaker	Emphysema	Liver disease	Joint pain	Memory loss
Heart failure	Cough	Gall bladder	Cramps	Speech trouble
Foot edema	Hemoptysis	Swallowing diff	Carpal tunnel	Tremors
Valve disease	Sleep Apnea	Blood in stool	Gait trouble	Numbness
Atrial-Fibrillation			Joint replacement	Migraines

Circle if a relative has Hypertension Stroke Cancer Heart Disease Diabetes Migraines

List any other family illness: _____

TOBACCO USE _____ PACK/DAY _____

CAFFEINE _____ SERVINGS/DAY (COFFEE, COLA, etc)

ALCOHOL USE _____ DRINKS PER DAY/WEEK/MONTH