NervePro™

MEDICAL HISTORY FORM

Name: ..... Age: ..... Race: .....

Chief Complaint to Neurologist: .....

Date symptoms started: ..... Medication Allergies .....

CIRCLE TESTS YOU HAVE HAD

EEG MRI BRAIN MRI SPINE CT SCAN EMG/NCV

MEDICATIONS	DOSE/MG	FREQUENCY	REASON USED	START DATE (EST)
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....

OPERATIONS	DATE	MAJOR ILLNESSES	ONSET
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

CHECK IF YOU HAVE:

GENERAL
- ❑ Fever
- ❑ Malaise
- ❑ Weight gain
- ❑ Weight loss
- ❑ Anemia

EYE
- ❑ Eye pain
- ❑ Glaucoma
- ❑ Blurred vision
- ❑ Double vision
- ❑ Temp loss of vision

SKIN
- ❑ Rash
- ❑ Psoriasis
- ❑ Melanoma
- ❑ Acne
- ❑ Skin Cancer

EAR NOSE THROAT
- ❑ Hearing loss
- ❑ Tinnitus
- ❑ Hoarse voice
- ❑ Vertigo

GENITO URINARY
- ❑ Hematuria
- ❑ Prostate Disease
- ❑ Incontinence
- ❑ Kidney stones
- ❑ Bladder infections

CARDIOVASC
- ❑ Chest pain
- ❑ Palpitation
- ❑ Pacemaker
- ❑ Heart failure
- ❑ Foot edema
- ❑ Valve disease
- ❑ Atrial-Fibrilation

RESPIRATORY
- ❑ Asthma
- ❑ Shortness of breath
- ❑ Emphysema
- ❑ Cough
- ❑ Hemoptysis
- ❑ Sleep Apnea

GASTROINTEST
- ❑ Heartburn
- ❑ Nausea
- ❑ Liver disease
- ❑ Gall bladder
- ❑ Swallowing diff
- ❑ Blood in stool

MUSCLE SKELETAL
- ❑ Neck pain
- ❑ Back pain
- ❑ Joint pain
- ❑ Cramps
- ❑ Carpal tunnel
- ❑ Gait trouble
- ❑ Joint replacement

NEUROLOGICAL
- ❑ Stroke
- ❑ Seizures
- ❑ Memory loss
- ❑ Speech trouble
- ❑ Tremors
- ❑ Numbness
- ❑ Headache

List any family illness: .....

TOBACCO USE ..... PACK/DAY .....

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

ALCOHOL USE ..... DRINKS PER DAY/WEEK/MONTH