INFORMATION FOR YOUR PHYSICIAN

Pt #________________________

TODAY'S DATE ___________ PATIENT NAME ____

I. Chief Complaint

Please write the reason you came to the doctor at this time: ____

____

When did your symptons begin?____

Have you seen a neurologist previously? YES or NO

If yes, what is the neurologist's name? ____

Who is your primary care physician?____

Who referred you to us?____

Are you seeing us today about a motor vehicle accident? YES or NO

Are you seeing us today about a workers compensation injury? YES or NO

If yes, what is the date of accident/injury? ______________________________

II. Patient Demographics

Age ___________ Height ____________ Weight ____________

III. Past Medical History

Please circle each illness or condition YOU have had.

AIDS	Diabetes	Lupus
Asthma	Glaucoma	Mental Illness
Attention Deficit Disorder	Headache	Muscle/nerve disorder
Back Pain	Heart Attack	Neck Pain
Bleeding tendencies	Heart disease	Palpitations
Cancer	Hepatitis	Pneumonia
Childhood Chicken Pox	HIV	Rheumatoid arthritis
Childhood Measles	High blood pressure	Shortness of breath
Childhood Mumps	High cholesterol	Stroke
Childhood Polio	Kidney disease	Syphilis
Childhood Rheumatic Fever	Liver Disease	Thyroid disease
Childhood Scarlet Fever	Jaundice	

Other ____

IV. Allergies

List medications or substances to which you have allergic reaction or sensitivity.

☐ Please check box if there are no known medication allergies.

I am allergic to the following:

1 Medication/substance ____
Describe reaction ____
2 Medication/substance ____
Describe reaction ____
3 Medication/substance ____
Describe reaction ____
4 Medication/substance ____
Describe reaction ____
5 Medication/substance ____

V. Family History

Please circle the illnesses which occurred in any of your blood relatives

Unknown	Headache	Pulmonary/lung disease
Allergy	Heart disease	Seizures
Asthma	High blood pressure	Sickle cell disease
Bleeding tendency	Kidney disease	Stroke
Cancer	Mental illness	Thyroid disease
Dementia/loss of memory	Multiple sclerosis	Tremor
Diabetes	Muscle/nerve disorder	Tuberculosis

Other ____

Please give the following information about your immediate blood relatives:

Father = is he living? YES or NO

If Yes, give age____________________

List any major illnesses ____

If No, what was the cause of death____

If No, give age at death________________________________

Mother = is she living? YES or NO

If Yes, give age____________________

List any major illnesses ____

If No, what was the cause of death____

If No, give age at death________________________________

Siblings - # brothers ___________________ # sisters _____________ Current Ages ________________________________

List any major illnesses in your brothers or sisters: ____

____

____

Children - # sons __________________ # daughters _______________ Current Ages ________________________________

List any major illnesses in your children: ____

____

____

VI. Social History

Caffeine
Do you drink caffeine-containing beverages? YES or NO
Use: Minimal Moderate Heavy
Daily amount __________________________________

Tobacco
Do you use tobacco now? YES or NO
In the past? YES or NO
If yes, circle appropriate statement:
Stopped Recently Stopped Several Years Ago Stopped Many Years Ago
Tobacco Source: Cigarette Chew Cigar Pipe Dip Other______________________
Daily amount __________________________________
Duration in years:_______________________________

Alcohol
Do you use alcoholic beverages? YES or NO
Previous user? YES or NO
Weekly amount ________________________________

Illegal drugs
Do you use recreational or illegal drugs? YES or NO
Type ____
Previous user? YES or NO
Type ____

Place of birth ____

Education ____________________________ Age on Completion __________________

(highest level attained)

Occupation ____

How long in current occupation ____________________________

Maiden name ___________________________________

Where and when have you lived or traveled outside of the US? ____

Marital History

Married? YES or NO

If YES, what is length of marriage/ _________________________

Divorced? YES or NO

Single (never married)? YES or NO

Widowed? YES or NO

Sexual History

Are you sexually active? YES or NO

Living Will

Do you have a living will? YES or NO

Exercise Circle one.

None

Exercise: MINIMALLY OFTEN REGULARLY

How often do you exercise per week?_______________________

Diet Circle all that apply.

		No added sweets	
No specific diet regimen	No added salt	Vegetarian	Weight reduction
Diabetic	Low saturated fat		

VII. Medications

Please name or otherwise identify medicines now or recently used.

	Medication	Strength (# mgs.)	Frequency (# times/day)
1	________________________ Taking/using now? YES or NO	__________	____________________
2	________________________ Taking/using now? YES or NO	__________	____________________
3	________________________ Taking/using now? YES or NO	__________	____________________
4	________________________ Taking/using now? YES or NO	__________	____________________
5	________________________ Taking/using now? YES or NO	__________	____________________
6	________________________ Taking/using now? YES or NO	__________	____________________
7	________________________ Taking/using now? YES or NO	__________	____________________
8	________________________ Taking/using now? YES or NO	__________	____________________
9	________________________ Taking/using now? YES or NO	__________	____________________
10	________________________ Taking/using now? YES or NO	__________	____________________
11	________________________ Taking/using now? YES or NO	__________	____________________
12	________________________ Taking/using now? YES or NO	__________	____________________

Menstrual History: Females patients only

Are you pregnant? YES or NO

Date of onset of last period________________________ Periods are: Regular Irregular

Are you taking oral contraceptives? YES or NO

Number of pregnancies______________________

VIII. Surgical History. **Have you had surgery? YES or NO**

If Yes, list surgery and year

1 ____

If Yes, list surgery and year

2 ____

If Yes, list surgery and year

3 ____

If Yes, list surgery and year

4 ____

If Yes, list surgery and year

5 ____

If Yes, list surgery and year

6 ____ YES or NO

Have you been hospitalized for an illness not requiring operation?

If Yes, describe____

If Yes, describe____

If Yes, describe____

Have you had serious injuries, broken bones, etc.? YES or NO

If Yes, describe____

If Yes, describe____

Have you had a blood transfusion? YES or NO

Date(s)_______________________________________

Date_________________Patient Signature____