

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 symptoms 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. Past Medical History

Please circle each illness or condition YOU have had.

- | | | |
|----------------------------|------------------------|-----------------------|
| AIDS | Heart attack | Muscle/nerve disorder |
| Asthma | Heart disease | Neck Pain |
| Attention Deficit Disorder | Hepatitis | Palpitations |
| Back Pain | HIV | Pneumonia |
| Bleeding tendencies | High blood pressure | Rheumatoid arthritis |
| Cancer | Kidney disease | Shortness of breath |
| Diabetes | Liver disease/jaundice | Stroke |
| Glaucoma | Lupus | Syphilis |
| Headache | Mental illness | Thyroid disease |

Other _____

Other _____

III. Surgical History.

Have you had surgery?

YES or NO

If Yes, list surgery and year

1 _____

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 If Yes, list surgery and year

Have you been hospitalized for an illness not requiring operation? YES or NO

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) _____

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 _____

IV. Childhood Diseases

Circle the childhood diseases you have had.

Asthma Measles Polio Scarlet Fever
Chicken Pox Mumps Rheumatic fever Other _____

V. Social History

Age _____ Place of Birth _____
Race/Nationality/Ethnic Background _____
(for hereditary diseases)
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? _____

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 _____

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

VI. 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: _____

VII. Medications Please name or otherwise identify medicines now or recently used.

(Enter Medications from the "Summary Page, Patient Allergies".

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		

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

(Enter Allergies in "Summary Page, Patient Allergies.")

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 _____

Date _____ Patient Signature _____

revised - 5-03