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	Seizures
Childhood Mumps	High cholesterol	Shortness of breath
Childhood Polio	Kidney disease	Stroke
Childhood Rheumatic Fever	Liver Disease	Syphilis
Childhood Scarlet Fever	Jaundice	Thyroid disease

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 specific diet regimen | No added salt | No added sweets | 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_____