



NEUROLOGY CLINIC - HEALTH HISTORY QUESTIONNAIRE

PATIENT INFORMATION			
Date	Name		
SSN	DOB	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/Widower			
Current Job		Employer	
Previous Job		Employer	
Referring Physician			
Other Providers			

CHIEF COMPLAINT	
Reason for today's visit	

PERSONAL HEALTH HISTORY			
Childhood Illnesses	<input type="checkbox"/> Measles <input type="checkbox"/> Mono	<input type="checkbox"/> Rubella <input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio
Medical Problems Diagnosed by Other Physicians			

Surgery/Hospitalization	Reason	Age at Treatment

FAMILY HEALTH HISTORY

	Age	Age at Death	Health Issue or Cause of Death
Mother			
Maternal Grandmother			
Paternal Grandmother			
Father			
Maternal Grandfather			
Paternal Grandfather			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			
Child			
Child			
Child			
Child			

MEDICATIONS (Prescription, Over the Counter, Vitamins, Inhalers)

	Medication	Qty / MG	Frequency		Medication	Qty / MG	Frequency
1				10			
2				11			
3				12			
4				13			
5				14			
6				15			
7				16			
8				17			
9				18			

Allergies to Medication	Type of Reaction

Please check any symptom that you are currently experiencing:

GENERAL

- Fever
- Weight Loss
- Night Sweats

ENDOCRINE

- Thyroid Problem/Goiter
- Diabetes

HEAD/EYES/EARS/NOSE/THROAT

- Vision Issues
- Dry Eyes
- Hearing Issues
- Ringing in Ears
- Nosebleeds
- Sinus Problems
- Dry Mouth

GASTROINTESTINAL

- Trouble Swallowing
- Indigestion/Heartburn
- Ulcers
- Frequent Constipation
- Frequent Diarrhea
- Hepatitis/Liver Disease
- Special Diet

PULMONARY

- Shortness of Breath
- Wheezing/Asthma/Emphysema
- Tuberculosis / Positive TB Test

CARDIOVASCULAR

- High Blood Pressure
- Heart Disease
- Heart Attack/Failure
- Heart Value Issue
- Heart Palpitation Rapid
- Heart Palpitation Slow
- High Cholesterol

NEUROLOGIC

- Headaches
- Seizures/Convulsions
- Numbness/Loss of Sensation
- Loss of Muscle Power
- Tremors/Shaking
- Concussion/Whiplash Injury
- Trouble Sleeping
- Snoring
- Falling Asleep Driving
- Trouble Walking
- Trouble with Speech
- Frequent Dizziness
- Motion Sickness
- Double Vision
- Stroke

HEMATOLOGIC

- Bruise/Bleed Easily
- Anemia
- Iron Deficiency
- B12 Deficiency

RHEUMATOLGIC

- Lupas/Sjogrens/Rheumatoid
- Arthritis/Joint Pain/Swelling
- Back/Neck Pain

DERMATOLOGIC

- Skin Problems
- Rash/Acne/Moles
- Malignant Melanoma
- Skin Cancer

PSYCHOLOGIC

- Major Stress
- Depression
- Panic
- Appetite/Eating Issues
- Frequent Crying
- Suicide Attempt
- Thoughts of Hurting Yourself
- Trouble Sleeping
- Stress at Home
- Stress at Work
- Other Stress

WOMEN ONLY-GENITOURINARY

- Number of Pregnancies _____
- Number of Live Births _____
- Pregnant
- Breastfeeding
- Hysterectomy
- Bladder Problems
- Kidney Disease

MEN ONLY-GENITOURINARY

- Frequent Night Urination
- Number of Times per Night _____
- Bladder Problems
- Erection/Ejaculation Issues
- Kidney Disease

SOCIAL HISTORY

Do you use tobacco/chew?

- Yes No Past

Cigarettes/chew per day? _____

Years of tobacco use? _____

Years since stopping? _____

Drink more than 2 alcoholic beverages per day?

- Yes No Past

Coffee/Caffeine usage per day? _____

Recreational Drugs-Cocaine, Mariuana, methamphetamine?

- Yes No Past

Toxic Exposure?

- Yes No Past