Tri-City Neurology Health History Questionnaire.

Your answers on this form will help your health care provide better understand your medical concerns. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICKTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc. and how it affects you)

ALLERGY	REACTION
1.	
2.	
3.	

PREFERRED PHARMACY

_____

MEDICATIONS

Please list all the medications you are currently taking , including over the counter medications

DRUG NAME	DOSE/Frequency
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

PAST MEDICAL HISTORY

- ☐ Diabetes
- ☐ Hypertension
- ☐ Cholesterol problems
- ☐ Strokes /TIA
- ☐ Seizures
- ☐ Anxiety
- ☐ Migraines
- ☐ Headaches
- ☐ Head trauma
- ☐ Heart disease
- ☐ Brain aneurysms
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Cancer
- ☐ Sleep problems
- ☐ Numbness, tingling
- ☐ Back pain
- ☐ Neck pain
- ☐ Tremor
- ☐ Parkinson's

PAST SURGICAL HISTORY

SURGERY	YEAR	Hospital
1.		
2.		
3.		
4.		
5.		

SOCIAL HISTORY

Smoking status ☐ Never ☐ Used to ☐ Everyday ☐ Someday ☐ Unknown
If smoking _____Cig/day _____Packs/day _____Years of smoking
_____ Years quit

Dominant hand ☐ RIGHT ☐ LEFT ☐ BOTH ☐ UNKNOWN

-Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Separated ☐ Domestic Partner

-Caffeine	☐ None	☐ Occasional	☐ Moderate	☐ Heavy
-Alcohol	☐ None	☐ Occasional	☐ Moderate	☐ Heavy
-Chewing tob	☐ None	☐ _____ /day		

-Street Drugs ☐ None ☐ Marijuana ☐ Crack/cocaine ☐ amphetamines ☐ Others

-Occupation _____
-Exercise ☐ None ☐ Mild ☐ Disabled ☐ Moderate ☐ Heavy

Other information: _____
_____
_____

FAMILY HEALTH HISTORY

☐ Diabetes
☐ Stroke
☐ Seizures
☐ Migraines
☐ Dementia
☐ Heart disease
☐ Depression
☐

☐ Blood pressure problems
☐ TIA
☐ Tremor
☐ Headaches
☐ Alzheimer's
☐ Brain cancer
☐ Anxiety
☐

☐ Cholesterol problems
☐ Brain aneurysms
☐ Parkinson's
☐ Multiple Sclerosis
☐ Bleeding problems.
☐ Spine cancer
☐ Other
☐

REVIEW OF SYSTEMS

Please √ all that apply:

General
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weight gain
- ☐ Weight loss

Ear/Nose/Throat
- ☐ Ear pain
- ☐ Difficulty hearing
- ☐ Dry mouth
- ☐ Frequent nosebleeds
- ☐ Mouth ulcers
- ☐ Sinus pressure
- ☐ Ringing in ears

RESPIRATORY
- ☐ Cough
- ☐ Shortness of breath
- ☐ Blood with coughing
- ☐ Wheezing
- ☐ Snoring
- ☐ Sleep apnea

Cardiovascular
- ☐ Chest pain on exertion
- ☐ Chest pressure/heaviness
- ☐ Palpitations
- ☐ Light-headed on standing
- ☐ Breathing problem lying down
- ☐ Breathing problem walking
- ☐ Swelling in legs

Musculo-skeletal
- ☐ Back pain
- ☐ Neck pain
- ☐ Muscle aches
- ☐ Joint pain
- ☐ Shoulder pain

Psychiatric
- ☐ Depression/mania
- ☐ Anxiety
- ☐ Insomnia
- ☐ Panic attacks
- ☐ Personality problems
- ☐ Fear for safety
- ☐ Schizophrenia

EYES
- ☐ Vision change
- ☐ Double vision
- ☐ Droopy eyes
- ☐ Color vision problems
- ☐ Eye redness /dryness.
- ☐ Blindness

SKIN
- ☐ Skin rash
- ☐ Itching
- ☐ Skin growth/mass
- ☐ Eczema
- ☐ Easy bruising

Endocrine
- ☐ Appetite change
- ☐ Increased thirst
- ☐ Hot flashes
- ☐ Increased sweating

Neurological
- ☐ Seizures
- ☐ Weakness
- ☐ Headaches/migraines
- ☐ Memory problems.
- ☐ Dizziness
- ☐ Vertigo
- ☐ Restless leg syndrome
- ☐ Sleep problems
- ☐ Fainting
- ☐ Numbness/tingling
- ☐ Stroke symptoms
- ☐ Attention problems
- ☐ Confusion
- ☐ Problem speaking
- ☐ Tremor

Gastrointestinal
- ☐ Abdominal pain
- ☐ Difficulty swallowing
- ☐ Bloody stool
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting

Genitourinary
- ☐ Loss of bladder control
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Prostate problems

Allergic/immunology
- ☐ Frequent sneezing
- ☐ Itching
- ☐ Hives
- ☐ Immune deficiency

Please add any other information about your health that you would like your provider to know here

_____

_____

_____

_____

_____

_____ _____

Patient/Parent/Guardian/ Caregiver Signature Date