Tri-city neurology LLC
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Health history questions

The health related questions are to help understand your medical problems. All questions are OPTIONAL and confidential.

Date of Visit: _____
Main reason for today's visit: _____
Other concerns:_____

ALLERGIES

List any allergies to medications

ALLERGY	REACTION
1._____	_____
2._____	_____
3._____	_____

_____

PREFERRED PHARMACY

_____

MEDICATIONS

List current medications: OR provide a separate.

DRUG NAME	DOSE
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____
7._____	_____

PAST MEDICAL HISTORY

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

SURGICAL HISTORY

_____
_____
_____
_____

SOCIAL HISTORY

Smoking status ☐Never ☐Used to ☐ Somedays ☐ Unknown
☐ Daily _____Packs/day. _____Cig/day _____Years of smoking

Dominant Hand ☐RIGHT ☐LEFT ☐BOTH ☐Unknown

Marital status ☐Married ☐Divorced ☐Single ☐Widow
☐Domestic partner ☐Separated

Caffeine use ☐None ☐Some ☐Moderate ☐Heavy

Alcohol use ☐None ☐Some ☐Moderate ☐Heavy

Chewing tobacco ☐None ☐Some ☐Moderate ☐Heavy

Exercise ☐None ☐Some ☐Moderate ☐Heavy

Street Drugs ☐None ☐Weed ☐Cocaine ☐Meth ☐Other

Living Situation ☐Alone ☐With others ☐Other_____

Occupation ☐None ☐Disabled ☐Retired ☐_____

FAMILY HISTORY ☐Adopted

☐Diabetes ☐Blood pressure ☐Cholesterol problems
☐Stroke ☐TIA ☐Brain Aneurysm
☐Seizure ☐Tremor ☐Parkinson's
☐Migraines ☐Headaches ☐Multiple Sclerosis
☐Dementia ☐Alzheimer's ☐Bleeding problems
☐Heart disease ☐Brain cancer ☐Spine problems.
☐Depression ☐Anxiety ☐Other_____
☐Unknown ☐_____ ☐_____

Review of systems [✓ all that applies to you]

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

Ear/Nose/Throat
- ☐Ear pain
- ☐Difficulty hearing
- ☐Dry mouth
- ☐Nose bleeds
- ☐Mouth ulcers
- ☐Sinus pressure
- ☐Ear ringing
- ☐_____

Respiratory
- ☐Cough
- ☐Shortness of breath
- ☐Bloody cough
- ☐Wheezing
- ☐Snoring
- ☐Sleep apnea

Cardiovascular
- ☐Chest pain with exertion
- ☐Chest pressure/heaviness
- ☐Palpitation
- ☐Light-headed on standing
- ☐Breathing problem lying
- ☐Breathing problems walking
- ☐Leg swelling
- ☐_____
- ☐_____
- ☐_____
- ☐_____

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

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

Eyes
- ☐Vision change
- ☐Double vision
- ☐Droopy eyes
- ☐Color vision problems
- ☐Eye redness/dry eyes
- ☐Blindness

Skin
- ☐Skin rash
- ☐Itching
- ☐Skin growth
- ☐Eczema
- ☐Easy bruising

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

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

GI
- ☐Abdominal pain.
- ☐Difficulty swallowing
- ☐Bloody stool.
- ☐Indigestion.
- ☐Nausea
- ☐Vomiting.

GU/OBGYN
- ☐Loss of bladder control
- ☐Difficulty urinating
- ☐Blood in urine
- ☐Prostate problems.
- ☐_____

Allergy/Immunology.
- ☐Frequent sneezing
- ☐Itching
- ☐Hives
- ☐Immune deficiency

Other comments:_____

_____
Patient/guardian signature