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NEUROLOGY PATIENT HISTORY PART I

You have an appointment to see Dr. _____, a specialist in the practice of neurology on _____. Please complete the questions below carefully before your scheduled appointment and bring the completed form with you.

DATE:_____ WEIGHT:_____
NAME:_____ HEIGHT:_____
AGE: _____ HANDEDNESS: R / L (circle one)

NAME OF THE PRIMARY CARE PHYSICIAN WHO SHOULD RECEIVE THE REPORT OF THIS CONSULTATION:_____.

COMPLAINT(S): List the main problem(s) for which you are seeking neurological consultation (i.e., Headache, pain, weakness, etc.)

_____

_____

DESCRIBE YOUR MAIN PROBLEM IN DETAIL:

Date of onset (approximate):_____

Describe symptoms in detail:_____

_____

_____

_____

_____

Please check list all **major medical problems/diseases** you have had (i.e., diabetes, hypertension, cancer, etc.)

- ☐ Hypertension
- ☐ Diabetes Mellitus
- ☐ Cancer/Where?
- ☐ Stroke
- ☐ Heart disease
- ☐ Seizures
- ☐ Headaches
- ☐ Neck Pain
- Back Pain
- Sleep disorder
- Depression/Anxiety
- Hand Pain/Numbness
- Other:_____
  _____

PLEASE FILL NEXT PAGE AS WELL!

NEUROLOGY PATIENT HISTORY PART II

SOCIAL HISTORY:

CIRCLE ONE

Married Single Divorced Other

Occupation:_____ Alcohol Per day: _____

Tobacco Per day:_____ Recreational Drugs:_____

Caffeinated Beverages:_____ How much:_____

FAMILY HISTORY:

	YES/NO	RELATIONSHIP
Hypertension:	____	_____
Diabetes:	____	_____
Kidney Disease:	____	_____
Tuberculosis:	____	_____
Muscular Dystrophy:	____	_____
Seizure Disorder:	____	_____
Headache/Migraine:	____	_____
Other	____	_____
	____	_____

LIST ALL MEDICATIONS: (Include birth control pills, any aspirin products, and over the counter medications)

NAME OF DRUG	DOSE	HOW OFTEN	DATE STARTED	PRESCRIBED BY
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

ALLERGIES (if any):_____