HC HIGHLAND CLINIC

DATE: _____
Provider you are seeing today
☐ **Harris** ☐ **Scaltsas** ☐ **Spikes**

HIGHLAND CENTER FOR
Neurology

PCP/REFERRING MD
_____

PATIENT HISTORY FORM

Name:_____DOB:_____Age:_____

Reason for Visit:_____

Review of Systems: ***Do you have?***

☐ Fatigue	☐ Sore Throat	☐ Abdomen Pain	☐ Abnormal Sleep ☐ Dizziness
☐ Insomnia	☐ Snoring	☐ Constipation	☐ Hair Loss
☐ Weight Loss	☐ Shortness of Breath	☐ Diarrhea	☐ Tremors
☐ Headache	☐ Known TB Exposure	☐ Nausea/Vomiting	☐ Memory Impairment
☐ Double Vision	☐ Cough	☐ Painful Urination	☐ Rash
☐ Visual Loss	☐ Chest Pain	☐ Frequent Urination	☐ Back Pain
☐ Hearing Loss	☐ Irregular Heartbeat	☐ Nighttime Urination	☐ Weakness
☐ Ear Infections	☐ Fainting	☐ Menses regular	☐ Bleeding
☐ Ringing Ears	☐ Leg Pain	☐ Menses irregular	☐ Bruising
☐ Nose Bleeds	☐ Varicose Veins	☐ Muscle Pain/Cramps	☐ Asthma
☐ Sinus Problem	☐ Edema	☐ Birth Control	☐ Seizures

Past Medical History:
Do you have?

☐ None	☐ Cancer	☐ Arthritis
☐ Heart Disease	☐ Depression	☐ Fibromyalgia
☐ Lung Disease	☐ Liver Disease	☐ Mitral Valve Prolapse
☐ Diabetes	☐ Kidney Disease	☐ Thyroid Disease
☐ Osteoporosis	☐ Asthma	☐ High Blood Pressure
☐ Gout	☐ Other_____	

Past Surgical History:
Have you had? ☐ None

- ☐ Thyroid
- ☐ Appendectomy
- ☐ Hysterectomy
- ☐ Wisdom Teeth
- ☐ Gallbladder
- ☐ Tonsillectomy
- ☐ Other_____

Family History:

☐ High Blood Pressure	☐ Cancer
☐ Heart Disease	☐ Depression
☐ Lung Disease	☐ Liver Disease
☐ Diabetes	☐ Kidney Disease
☐ Osteoporosis	☐ Fibromyalgia
☐ Other_____	☐ None

Social History:

Occupation:_____
Disability: ☐ yes ☐ no
Litigation: ☐ yes ☐ no
Tobacco Use ☐ current ☐ former ☐ never
Type: _____ amt / day
Alcohol Use ☐ yes ☐ no
Illicit drug use ☐ yes ☐ no
Height _____ Weight _____

Allergies: ☐NONE - ***list reaction for each allergy***_____

Medications: *Drug Name Dose/Strength How you take it (for example, once a day, twice a day, etc)* ☐ None

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____