

DATE: _____
MD you are seeing today

**HIGHLAND CENTER FOR
Neurology**

PCP/REFERRING MD

PATIENT HISTORY FORM

Name: _____ DOB: _____ Age: _____

Reason for Visit: _____

Review of Systems: *Do you have?*

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

Past Medical History:

Do you have?

- | | | |
|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Other _____ | |

Past Surgical History:

Have you had? None

- | |
|--|
| <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Wisdom Teeth |
| <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Other _____ |

Family History:

- | | |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> None |

Social History:

- Occupation: _____
- Dominant Hand: R L
- Tobacco Use Yes No
- Alcohol Use Yes No
- Height _____ Weight _____

***** Allergies:** NONE or list each allergy _____

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

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____