HEALTH HISTORY

Welcome to Neurology Associates, Inc. Please fill out the information below to the best of your ability.

Patient Name:_____ Date:_____
SSN:_____ DOB:_____ [ ] Male [ ] Female

REASON FOR VISIT:	

FAMILY HISTORY: If any blood relative has suffered any of the following, please circle the number and indicate which relative

1) Epilepsy	6) Thyroid	11) Osteoporosis	16) High Cholesterol	
2) Migraine	7) Hayfever	12) Arthritis	17) Alcoholism	
3) Mental illness	8) Asthma	13) Cancer	18) Heart Disease	
4) Glaucoma	9) Anemia	14) Stroke	19)	
5) Diabetes	10) Bleeds easily	15) Hypertension	20)	

HOSPITAL ADMISSIONS Not including pregnancies	**Year**	**Illness or Operation**	**Year**	**Illness or Operation**

MEDICATIONS: List all medications you are now taking, including those you buy without a prescription and any herbal medicines.			**ALLERGIES**	**VACCINES** (Year of last)	**TEST/EXAM** (Year of last)
				Tetanus / Td:	Rectal/stool:
				Influenza (flu):	Cholesterol:
				Pneumonia:	Eye Exam:
				Hepatitis:	TB Test:

MEDICAL HISTORY: Mark (C) for Current Problems. Check (✓) and indicate age when you had any of the following symptoms or diseases.

- ❑ Decreased hearing
- ❑ Ringing in ear
- ❑ Ear infections – frequent
- ❑ Dizzy spells
- ❑ Failing vision
- ❑ Fainting spells
- ❑ Eye pain
- ❑ Double or blurred vision
- ❑ Nose bleeds—recurrent
- ❑ Sinus trouble
- ❑ Sore throats—frequent
- ❑ Hoarseness—prolonged
- ❑ Havfever / Allergies
- ❑ Pneumonia / Pleurisy
- ❑ Bronchitis / Chronic Cough
- ❑ Asthma / Wheezing
- ❑ Shortness of breath:
  - ❑ On exertion
  - ❑ Lying flat
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Heart Murmur
- ❑ Swollen Ankles
- ❑ Irregular Pulse
- ❑ Palpitations
- ❑ Leg pain—when walking
- ❑ Varicose veins / Phelbitis
- ❑ Loss of appetite—recent
- ❑ Difficulty swallowing
- ❑ Heartburn
- ❑ Peptic Ulcer
- ❑ Persistent nausea / Vomiting
- ❑ Abdominal Pain—chronic
- ❑ Gall bladder trouble
- ❑ Jaundice / Hepatitis
- ❑ Diarrhea
- ❑ Constipation
- ❑ Diverticulosis
- ❑ Bloody or tarry stools
- ❑ Hemorrhoids
- ❑ Hernia
- ❑ Urine infections—frequent
- ❑ Blood in urine
- ❑ Kidney Stones
- ❑ Urination
- ❑ Venereal disease
- ❑ Urethral discharge
- ❑ Chronic fatigue
- ❑ Weight-loss
- ❑ Weight gain—recent
- ❑ Anemia
- ❑ Bruise easily
- ❑ Cancer
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ Seizures
- ❑ Stroke
- ❑ Tremor / hands shaking
- ❑ Numbness / tingling
- ❑ Headaches—frequent
- ❑ Arthritis / Rheumatism
- ❑ Back pain—recurrent
- ❑ Bone/joint injury
- ❑ Gout
- ❑ Osteporosis
- ❑ Foot pain
- ❑ Cold numb feet
- ❑ Rashes
- ❑ Hives
- ❑ Psoriasis
- ❑ Eczema
- ❑ Sleeping or concentration difficulty
- ❑ Depression
- ❑ Nervousness
- ❑ Agitation
- ❑ Memory loss
- ❑ Moodiness
- ❑ Suicidal thoughts
- ❑ Phobias
- ❑ Mental illness
- ❑ Feelings of worthlessness
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Chicken Pox
- ❑ Polio
- ❑ Mumps
- ❑ Measles
- ❑ German Measles
- ❑ Tuberculosis
- ❑ Herpes
- ❑ HIV / AIDS
- ❑ Alcohol ____oz per week
- ❑ Smoking ___cig/day ___# years
- ❑ Coffee/Tea ___cups/day
- ❑ Recent hair loss

FEMALES:

Menstrual flow:
Days of flow_____
1st day of last period_____
Pain / Bleeding during, after sex

Number of:
Pregnancies___ Abortions___
Miscarriages___Live births___

Birth control method:
Method:_____
B.C. pill name_____

- ❑ Flushing/ Menopause

Date of last PAP test
- ❑ Normal
- ❑ Abnormal

Date of last Mammogram
- ❑ Normal
- ❑ Abnormal

NOTES/Other: