MedicalCenter Clinic
HEALTHCARE CENTERED AROUND YOU

# Neurology History Form

Date: ____________________

Referring Physician: ________________________________

Reason for Evaluation: ______________________________

## Medical History:

**MEDICATIONS:** List any drug or medication that you take.

__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________

**ALLERGIES:** List any allergies you have.

__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________

## PAST HISTORY:

| | | | |
|---|---|---|---|
| ☐ Headache | ☐Peripheral Nerve | ☐High Blood Pressure | ☐Epilepsy |
| ☐Cancer | ☐Lung Disease | ☐Stroke | ☐Depression |
| ☐Ulcers | ☐Arthritis | ☐Heart Disease | ☐Bleeding |
| ☐Spinal Cord Injury | ☐Anemia | ☐Meningitis | ☐Diabetes |
| ☐Peripheral Vascular Disease | ☐Thyroid Disease | ☐Hepatitis | ☐STD |
| ☐Kidney/ GU Disease | ☐Venereal Disease | ☐TB | ☐HIV |
| ☐Syncope/Fainting | ☐Pregnancy #_____ | ☐Blood Transfusions | ☐Anxiety |
| ☐Personality Changes | ☐Edema/Swelling | ☐Hematolgical/Lymphadenopathy | |

Last Menstrual Cycle?_____________________________________________

## HOSPITALIZATIONS:

**Surgeries** (please list)

____________________________________________
____________________________________________
____________________________________________
____________________________________________

**HOSPITALIZATIONS other than for surgery (please list):**

____________________________________________
____________________________________________
____________________________________________
____________________________________________

## REVIEW OF SYSTEMS:

| | | | |
|---|---|---|---|
| ☐fatigue | ☐ weight loss/gain | ☐fevers | ☐night sweats |
| ☐ENT | ☐Cardiac | ☐Respiratory | ☐Sleep |
| ☐GI | ☐Musculoskeletal | ☐Dermatologic | ☐Appetite Chances |
| ☐Hallucinations | ☐Smell/Taste Difficulty | ☐Blurred Vision | ☐Double Vision |
| ☐Face Numb/Tingle | ☐Tinnitus | ☐incontinence | ☐Vertigo/Dizziness |
| ☐Dysphagia | ☐Decreased Hearing (right/left) | | ☐Hoarseness |
| ☐Weakness | ☐Numbness | ☐Stiffness/Pain | ☐Tremor |
| ☐Trouble Walking | ☐Memory Loss | ☐Poor Balance/Coordination | |

## SOCIAL HISTORY:

Occupation________________________________ Education__________________

Smoke/Tobacco:Yes No Alcohol:Yes No Illegal Drugs:Yes No

## FAMILY HISTORY:

| | | | |
|---|---|---|---|
| ☐ heart disease | ☐hypertension | ☐Diabetes | ☐Cancer |
| ☐Arthritis | ☐Stroke | ☐Bleeding Disorder | ☐Kidney Disease |
| ☐CNS Tumor | ☐Thyroid Disease | ☐Mental Illness | ☐Headache |
| ☐Neuromuscular | ☐Epilepsy | ☐Dementia | ☐Ataxia |
| ☐Siblings #_______ | ☐Father (L/D)______age | ☐ Mother (L/D)______age | |

______________________________ ______________________________

Patient's Signature Date