Northlake NEUROLOGY

Remarkable People. Remarkable Medicine.

MEDICAL HISTORY FORM

.

Name_____ DOB_____ MRN_____

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS

PATIENT HISTORY:
Cancer____
Hypertension ____
Anemia ____
Diabetes ____
Arthritis ____
Pneumonia ____
Tuberculosis ____
Rheumatic Fever __
Stroke ____
Tetanus Shot up to date ___
Heart Disease ____

ALLERGY:
Asthma ____
Hayfever ____
Hives ____
Allergic to Iodine/X-ray Dye
Allergic to Latex
Allergic to Adhesive Tape

BLOOD TRANSFUSION:
Blood Transfusion____
Reaction to blood ____
(If reacted please list type):

SOCIAL HISTORY:
Occupation:_____
Former Occupation (if retired)
_____
Marital Staus:_____
Highest Level of Education Completed:_____
College (number of years):
_____

HABIT:
Diet Restrictions (if yes, list)
_____
Use Tobacco (if yes,list number)
_____
Use Alchohol (if yes, list amount and how often)_____
Use Drugs (if yes, list amount and how often)_____
Problems Sleeping (if yes, list type_____

SEXUAL HISTORY:
HIV _____
Syphilis _____
Gonorrhea _____

REVIEW OF SYSTEMS:
SKIN:
Skin lesions ____

EYES:
Blurred Vision ____
Double Vision ____
Wear Glasses/contacts ____

EARS:
Deafness ____
Ringing in Ears ____
Dizzy spells ____

NOSE & THROAT
Upper Respiratory Infections____
Sinusitis ____
Tonsilltis ____
Nose Bleeds ___

MOUTH:
Mouth Lesions ____
Toothaches ____
Up to date w/dentist ___

LIVER:
Jaundice/Hepatitis ____

CARDIORESPIRATORY:
Irregular Pulse ____
Difficulty Breathing ____
Excessive Coughing ____
Cough up blood ____
Night Sweats ____
Ankle Swelling ____
Palpitations ____
Chest Pain ____
Heart Attack ____
Heart Murmur ____
Pacemaker ____

NEUROLOGIC:
Numbness/Tingling (if yes, list locations)_____
Convulsion/Seizures _____
Paralysis ____
Fainting ____
Headaches ____
Tremors ____

Patient Signature_____ Date_____

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GASTROINTESTINAL:
Nausea Vomiting ____
Vomiting blood ____
Abdominal Pain ____
Diarrhea ____
Constipation ____
Bloody Stool ____
Hemorrhoids ____
Peptic Ulcer/Internal bleeding _____

GENITOURINARY:
Incontinence ____
Frequent Urination ____
Excessive Urination at night ___
Urgnecy to Urinate ____
Difficult Urination ____
Kidney stones ____
Sexual dysfunction ____

MENSTRUAL:
Pregnancy(if yes, how many) _____
Miscarriage (if yes, how many) _____
Abortions (if yes, how many) _____
Complications with birth (if yes, list) _____
Abnormal Menstrual cycle (if yes, list type) _____
Living children (if yes,list number)
boys _____ girls _____

EXTREMITIES:
Varicose Veins ____
Leg Cramps ____
Deformities (if yes, list type) _____

PSYCHIATRIC:
Mental Illness ___
Depression ____
Nervousness ___

ENDOCRINE:
Intolerance to cold or heat ___
Excessive thirst ____
Excessive urination ____

ALLERGIES TO MEDICATIONS OR FOODS:
(List Name of Medications/Foods and Reaction):
_____
_____

SURGERIES/HOSPITALIZATIONS:
(List Surgeries/Hospitalizations and Approximate Dates):
_____
_____

ACCIDENTS/INJURIES:
(List Serious Accidents/Injuries and Approximate Dates):
_____
_____

Patient Signature_____ Date_____

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Name_____ DOB_____ MRN_____

FAMILY HISTORY:

FAMILY MEMBER	AGE(S)	LIVING/ DECEASED	CURRENT MEDICAL CONDITIONS/ CAUSE OF DEATH
FATHER			
MOTHER			
BROTHER(S)			
SISTER(S)			
CHILDREN			

PLEASE CHECK IF ANYONE IN YOUR FAMILY HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

	FATHER	MOTHER	SISTER(S)	BROTHER(S)	CHILDREN	GRANDPARENTS
Cancer						
Diabetes						
Heart Trouble						
Seizures						
Tremors						
Kidney Disease						
Blood Disease (if yes,type)						
HIV						
Hemophilia						
Hypertension						
Stroke						
Headaches						
Arthritis						
Birth Defects						
Alzheimer's disease						
Parkinson's disease						
Multiple Sclcrosis						

Patient Signature_____ Date_____

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Name_____ DOB_____ MRN_____

CURRENT MEDICATIONS:

Name of Medication	Dose	Times per day

PLEASE LIST THE PHARMACY WHERE YOU OBTAIN YOUR MEDICATIONS

Pharmacy Name	Location	Phone Number	Fax Number

PLEASE MARK WHICH TYPE OF INFORMATION WE MAY LEAVE ON YOUR VOICEMAIL OR ANSWERING MACHINE

All

☐ Prescription/Medication Information

☐ Test results

☐ Appointment Times

☐ Other: _____

PLEASE INDICATE YOUR PREFERRED CONTACT PHONE NUMBER

☐ Home Phone: _____

☐ Cell Phone: _____

☐ Work Phone: _____

Patient Signature_____ Date_____