

MEDICAL HISTORY QUESTIONNAIRE

(to be filled out by patient or family member)

Neurology Service

DATE
NAME
FMP/SSN
BIRTHDATE

Please respond to all items. If you fail to provide the required information, patient care may be compromised.

Referring provider's name and organization (if known): _____

What is the main reason you were referred to Neurology? _____

Do **YOU** have any of the following? If **YES**, please explain in the space provided.

GENERAL

Fever, Chills [] []
Change in weight [] []

EYES

Blurry/ Distorted vision [] []
Loss of side vision [] []
Double vision [] []
Droopy eyelid(s) [] []

EAR/NOSE/THROAT/NECK

Sinus congestion/infection [] []
Noise / ringing in ears [] []
Hearing loss [] []
Jaw pain when chewing [] []
Tongue pain [] []
Neck pain [] []

NEUROLOGICAL

Headache or facial pain [] []
Weakness in arms or legs [] []
Numbness or tingling [] []
Loss of smell or taste [] []
Dizziness or vertigo [] []
Speech problems [] []
Swallowing problem [] []
Coordination problems [] []
Difficulty walking [] []
Seizures or spells [] []
Loss of consciousness [] []

HEART/LUNGS

Chest pain [] []
Shortness of breath [] []
Palpitations (rapid heartbeat) [] []
Fainting [] []
Light-headedness [] []

OTHER

Skin condition (rash, etc.) [] []
Dry eyes /dry mouth [] []
Diarrhea or constipation [] []
Bladder control problem [] []
Bowel control problem [] []
Blood in urine [] []
Joint ache/ swelling [] []
Muscle ache/ pain [] []
Enlarged lymph nodes [] []
Easy bruising/ bleeding [] []
Difficulty sleeping [] []
Pain [] []

Is there a **FAMILY HISTORY** of any of the following?

	YES	NO	RELATIONSHIP
Diabetes	[]	[]	_____
High blood pressure	[]	[]	_____
High cholesterol	[]	[]	_____
Heart Attack	[]	[]	_____
Stroke/ TIA	[]	[]	_____
Epilepsy	[]	[]	_____
Migraine	[]	[]	_____
Cancer	[]	[]	_____
Gait Disorder	[]	[]	_____

PAST MEDICAL HISTORY (Diseases you are being treated for):

- _____
- _____
- _____
- _____
- _____

MEDICATIONS YOU TAKE (NAME, DOSE, FREQUENCY):

- _____
- _____
- _____
- _____
- _____

ALLERGIES :

HOSPITALIZATIONS:

ACCIDENTS or TRAUMA:

SURGERIES:

CURRENT OCCUPATION:

OTHER HISTORY: YES NO

Are you disabled? [] [] for how long? _____

Do you smoke or dip? [] [] _____ packs per day for _____ years

Do you drink alcohol? [] [] _____ drinks per day/week/month