

Northwest Neurology Health History Form

Your name: _____ Date of Birth: _____

Reason for visit: _____ Date of Visit: _____

Height: _____

Weight: _____

Review of Systems (please circle if you have had any of these symptoms in the last 3 months)

Neurological:

frequent headaches
numbness/tingling
weakness
poor balance
difficulty walking
dizziness
tremors
memory loss
difficulty swallowing
difficulty speaking
difficulty with sleep

Constitutional

recent weight change
fever
loss of appetite
night sweats
fatigue
recent weight charge
excessive thirst
hormone problems
cold/heat intolerance
recurrent infections

Eyes:

eye pain
visual loss
double vision

Respiratory:

coughing
shortness of breath
wheezing
snoring

Cardiovascular:

chest pain
palpitations
swelling in legs/feet
passing out

Psychiatric:

nervousness
change in mood
change in personality
hallucinations

Genitourinary:

frequent urination
painful urination
urinary incontinence
kidney stone
sexual difficulty

Ear/Nose/Throat:

hearing loss
ear pain
ringing in ears
sinus problems
nose bleeds

Gastrointestinal:

nausea
abdominal pain
diarrhea
blood in stool
bowel incontinence

Skin:

rashes
change in skin color
change in hair or nails

Musculoskeletal:

Joint pain
Joint swelling
Pain in arms or legs

Hematological:

excessive bleeding
swollen lymph nodes

Past Medical History (please circle any that apply)

Neurological:

seizures/epilepsy
Multiple Sclerosis
Parkinson's Disease
dementia
stroke or TIA
aneurysm
brain hemorrhage
head injury
neuropathy
Myasthenia Gravis
muscle disease
migraine
cluster headache
pinched nerve
abnormal MRI or CT

Rheumatological:

arthritis
Lupus
Sjogren's Disease
Scleroderma
autoimmune disease
abnormal ANA

Infectious Disease

pneumonia
HIV/AIDS
Tuberculosis
Syphilis
Lyme Disease
Chicken Pox
Shingles

Eyes:

glaucoma
macular degeneration
optic neuritis

Cardiovascular :

angina
heart attack
pacemaker
arrhythmia
passing out

Sleep:

sleep apnea
restless legs
insomnia

Hematological:

blood clot
anemia
hemophilia
low platelets
cancer(if yes, please
list types of cancer)

Surgeries:

General Medicine:

kidney disease
liver disease
diabetes
high blood pressure
high cholesterol
hyper or hypo thyroid
COPD
Asthma

Gastrointestinal:

ulcers
Barrett's Esophagus
gastritis
G.I. bleed
diverticulitis
colonic polyps
gluten sensitivity

Psychiatric:

anxiety
depression
psychosis

Any other past
medical history

Names of other medical specialists you have seen

Hospitalizations:

Medications:

Name of medicine	Dose	frequency	Name of medicine	Dose	frequency
1.			8.		
2.			9.		
3.			10.		
4.			11.		
5.			12.		
6.			13.		
7.			14.		

Please list your non-prescription medications, herbs and vitamins:

Allergies to medications:

Social history (please provide comment if necessary):

Do you smoke?
Do you consume alcohol?
Do you use illicit drugs?
Do you work outside your home?
Are you married?
Do you drink coffee?
Do you have children?
Do you have significant stress?

Family history:

Please indicate any important neurological conditions that may run in your family:

Neurological Condition	Relationship of affected individuals to patient (e.g. mother, brother)
Brain aneurysm	
Stroke	
Multiple sclerosis	
Parkinson's disease	
Seizures/epilepsy	
Migraine	
Neuropathy	
Muscular dystrophy	
Other	

Please list the illnesses that have affected immediate family members:

Family member	Medical conditions	Please indicate cause of death if deceased
Mother		
Father		
Brother (s)		
Sister (s)		

Please list any other illnesses that may run in your family and indicate who has been affected:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever has a change in my health.

Signature of Patient, Guardian or Personal Representative

Date

Please print name of Patient, Guardian, or Personal Representative

Relationship to Patient

Reviewed By

Date