

**NEUROLOGY PATIENT HEALTH HISTORY FORM**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Birthdate \_\_\_\_\_ Sex: M \_\_\_ Marital  
F \_\_\_ Status: \_\_\_\_\_ Occupation \_\_\_\_\_

Are you right or left handed? \_\_\_\_\_ Education \_\_\_\_\_

Medications: (Please list any medication you are presently taking, including Aspirin and dose, if known)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: (Please list any drug, food product or substance)  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY:** (Please circle)

Father: Age (now or at death) \_\_\_\_\_ Mother: Age (now or at death) \_\_\_\_\_

Medical Problems:

Father: \_\_\_\_\_ Mother: \_\_\_\_\_  
Brothers: \_\_\_\_\_ Sisters: \_\_\_\_\_

Has any blood relative ever had: (please circle)

	Yes	No	Relationship		Yes	No	Relationship
Headaches	Yes	No	_____	Psychiatric Illness	Yes	No	_____
Seizures	Yes	No	_____	Stroke	Yes	No	_____
Blindness	Yes	No	_____	Multiple Sclerosis	Yes	No	_____
Deafness	Yes	No	_____	High Blood Pressure	Yes	No	_____
Muscle weakness	Yes	No	_____	Diabetes	Yes	No	_____
Muscle wasting	Yes	No	_____	Cancer	Yes	No	_____
Incoordination	Yes	No	_____	Heart Trouble	Yes	No	_____
Abnormal movements	Yes	No	_____	Thyroid Disease	Yes	No	_____
Dementia	Yes	No	_____	Retardation	Yes	No	_____
				Depression	Yes	No	_____

**PERSONAL HISTORY:**

<u>Neurologic Review of Systems:</u>	(Circle)		Comments – Date of onset, if known
Head Trauma	Yes	No	_____
Loss of Consciousness	Yes	No	_____
Excessive Drowsiness	Yes	No	_____
Insomnia	Yes	No	_____
Neck Injury	Yes	No	_____
Back Injury	Yes	No	_____
Difficulty with: Thinking	Yes	No	_____
Mood	Yes	No	_____
Irritability	Yes	No	_____
Comprehension	Yes	No	_____
Calculation	Yes	No	_____
Reading/Writing	Yes	No	_____
Memory	Yes	No	_____
Fatigability	Yes	No	_____
Weakness	Yes	No	_____
Cramps	Yes	No	_____
Loss of Muscle Bulk	Yes	No	_____
Flickering Muscle Movements under the Skin	Yes	No	_____

(over)

Neurologic Review of Systems: (Cont'd)

Comments – Date of onset, if known

Involuntary Movements	Yes	No	_____
Difficulty Swallowing	Yes	No	_____
Slurred Speech	Yes	No	_____
Incoordination	Yes	No	_____
Loss of Balance	Yes	No	_____
Difficulty Walking	Yes	No	_____
Headache	Yes	No	_____
Pain	Yes	No	_____
Numbness	Yes	No	_____
Burning Sensations	Yes	No	_____
Change in Sense of Smell	Yes	No	_____
Changing Visual Acuity	Yes	No	_____
Double Vision	Yes	No	_____
Change in Sense of Taste	Yes	No	_____
Decreased Hearing	Yes	No	_____
Ringing in the Ears	Yes	No	_____
Light Headedness	Yes	No	_____
Vertigo (sense of spinning)	Yes	No	_____
Change in Sexual Interest	Yes	No	_____
Disturbance of: Tearing	Yes	No	_____
Salivation	Yes	No	_____
Sweating	Yes	No	_____
Nausea/Vomiting	Yes	No	_____
Urination	Yes	No	_____
Bowel Movements	Yes	No	_____
Sexual Function	Yes	No	_____
Depression	Yes	No	_____

Illnesses: (As far as you know, have you ever had or been told you had)

	Yes	No	Date		Yes	No	Date
Stroke (or TIA)	Yes	No	_____	Arthritis	Yes	No	_____
High Blood Pressure	Yes	No	_____	Thyroid Disease	Yes	No	_____
Seizures	Yes	No	_____	Rheumatic Fever	Yes	No	_____
Migraine Headaches	Yes	No	_____	Asthma	Yes	No	_____
Diabetes	Yes	No	_____	Heart Attack	Yes	No	_____
Cancer	Yes	No	_____	Heart Failure	Yes	No	_____

Medical Review of Systems:

	Yes	No	Date		Yes	No	Date
Swollen Glands	Yes	No	_____	Frequent Diarrhea or constipation, which?	Yes	No	_____
Cough	Yes	No	_____	Caffeine (coffee, tea, soft drinks) How many per day?	Yes	No	_____
Shortness of Breath	Yes	No	_____	Alcohol consumption	Yes	No	_____
Chest Pain	Yes	No	_____	If yes, how much per week?			_____
Palpitations	Yes	No	_____	Joint Swelling or Stiffness	Yes	No	_____
Irregular Heartbeat	Yes	No	_____	Chills, Night Sweats	Yes	No	_____
Heart Murmur	Yes	No	_____	Weight Gain or Loss in past year; which?	Yes	No	_____
Kidney Disease	Yes	No	_____	If so, how much?			_____
Venereal Disease	Yes	No	_____	Low Blood Count (anemic)	Yes	No	_____
Skin Rash	Yes	No	_____				
Fever	Yes	No	_____				
Easy Bruising of Skin	Yes	No	_____				
Smoker	Yes	No	_____				
If so, how much per day?			_____				

Previous Hospitalization and Surgeries not listed above:

\_\_\_\_\_

\_\_\_\_\_

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