

HUMBOLDT NEUROLOGY PATIENT HISTORY

Patient: _____ **DOB:** _____ **Date:** _____
Height: _____ **Weight:** _____ **Reason for visit:** _____

Family History For each of the following, please mark an X for each relative who has suffered from the condition.

	<u>Brother/Sister</u>	<u>Mother</u>	<u>Father</u>	<u>Grandmother</u>	<u>Grandfather</u>
Alzheimers/Dementia	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Migraine headaches	_____	_____	_____	_____	_____
Neuropathy	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Other neurological disease	_____	_____	_____	_____	_____

<u>Current Medication</u>	<u>Dosage</u>	<u>Reason for Taking</u>	<u>Past History / Surgery/ Hospitalization</u>	<u>Year</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Drug Allergies Name all medications that you are allergic to _____

Medical History Circle all of the following problems that you are currently suffering.

- | | | | | |
|----------------------|-----------------------|------------------------|-----------------|-------------------------|
| Anemia | Cold numb feet | Fatigue-loss of energy | Irregular Pulse | Seizures/Convulsions |
| Arthritis/Rheumatism | Depression | Fever | Memory loss | Sleeping difficulty |
| Asthma/Wheezing | Diabetes | Headaches-migraine | Mental illness | Stroke |
| Back pain-frequent | Dizziness | Headaches-severe | Moodiness | Thyroid disease |
| Bruise easily | Double/Blurred vision | Heart palpitations | Muscle weakness | Tingling sensations |
| Calf pain-walking | Fainting spells | High blood pressure | Night Sweats | Tremor/Hands shaking |
| Cancer (type _____) | | High cholesterol | Numbness | Weight gain/Weight loss |

Habits Do you smoke? YES NO If Yes, # packs/day? _____
 Do you drink alcohol? YES NO If Yes, # drinks/week? _____
 Do you drink coffee? YES NO If Yes, # cups/day? _____
 Do you exercise? YES NO If Yes, what type of exercise? _____
 How Often? _____