Date: _____/_____/_____

NEUROLOGY CLINIC
HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: ☐ **M** ☐ **F** **DOB** _____/_____/_____
(Last, First, M.I.) **AGE** ______

Please list your doctors (starting with the doctor who referred you here):

Doctor:	Specialty:

CHIEF COMPLAINT

What is the reason for your visit today? ____

____

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mono ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Operation:	Age or Year:

Other Hospitalizations:

Year	Reason

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name the Drug	How much?	When?	Name the drug	How much?	When?
1.)			6.)		
2.)			7.)		
3.)			8.)		
4.)			9.)		
5.)			10.)		

More on next page

Allergies **to Medications (please list medication and problem it caused):**

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Widower

Education: ☐GS ☐HS ☐GED ☐College ☐Postgraduate
Work History: Jobs held in past:______________________________ Current job:_______________________

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? ______

Alcohol: Do you drink alcohol? ☐ Yes ☐ No If yes, what kind?_______How many drinks per week? _____

Drugs:
Do you currently use recreational or street drugs (cocaine, methamphetamine, marijuana, etc)? …☐ Yes ☐ No

Tobacco:
Do you use tobacco? ☐ Yes ☐ No ☐ Cigarettes - Pks/day_____ ☐ Chew - #/day _____
☐ # of Years ____________ ☐ or Year Quit _____

Toxic exposures: please list any (lead, arsenic, solvents, mercury, etc) ________________________

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death
Father			
Mother			
Brothers and Sisters	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

	Age	Age at Death	Significant Health Problems or Cause of Death
Children	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
Grandparents (Mother's Side)			
Male			
Female			
Grandparents (Father's Side)			
Male			
Female			

REVIEW OF SYSTEMS:

GENERAL

Have you had recent fever? .... ☐ Yes ☐ No
Have you had recent weight loss?.. ☐ Yes ☐ No
Do you have frequent / severe night sweats? .... ☐ Yes ☐ No

ENDOCRINE

Do you have thyroid problems or goiter? .... ☐ Yes ☐ No
Do you have diabetes? .... ☐ Yes ☐ No

More on next page

HEAD, EYES, EARS, NOSE, AND THROAT

Question	Yes	No
Do you have vision (eyesight) problems?	☐ Yes	☐ No
Do you have dry eyes?	☐ Yes	☐ No
Do you have trouble hearing?	☐ Yes	☐ No
Do you have ringing in your ears?	☐ Yes	☐ No
Do you have nosebleeds?	☐ Yes	☐ No
Do you have hoarseness?	☐ Yes	☐ No
Do you have sinus problems?	☐ Yes	☐ No
Do you have dry mouth?	☐ Yes	☐ No

GASTROINTESTINAL

Question	Yes	No
Do you have trouble swallowing?	☐ Yes	☐ No
Do you have indigestion or heartburn?	☐ Yes	☐ No
Have you had ulcers?	☐ Yes	☐ No
Do you have frequent constipation?	☐ Yes	☐ No
Do you have frequent diarrhea?	☐ Yes	☐ No
Have you had hepatitis or liver disease (yellow jaundice)?	☐ Yes	☐ No
Do you have gallbladder disease?	☐ Yes	☐ No
Are you on a special diet? ________________________	☐ Yes	☐ No

PULMONARY

Question	Yes	No
Do you have shortness of breath?	☐ Yes	☐ No
Do you have wheezing, asthma, or emphysema?	☐ Yes	☐ No
Have you had tuberculosis or a positive TB test?	☐ Yes	☐ No

CARDIOVASCULAR

Question	Yes	No
Do you have hypertension (high blood pressure)?	☐ Yes	☐ No
Do you have heart disease (heart attack, heart failure, valve problem)?	☐ Yes	☐ No
Do you have a heart murmur?	☐ Yes	☐ No
Does your heart beat fast or slow (palpitations)?	☐ Yes	☐ No
Do you have high cholesterol?	☐ Yes	☐ No

NEUROLOGIC

Question	Yes	No
Do you have headaches?	☐ Yes	☐ No
Have you ever had a seizure or convulsion?	☐ Yes	☐ No
Do you have a loss of sensation (numbness) anywhere?	☐ Yes	☐ No
Do you have a loss of muscle power anywhere?	☐ Yes	☐ No
Do you have tremor (shaking)?	☐ Yes	☐ No
Have you had a concussion or whiplash injury?	☐ Yes	☐ No
Do you have trouble sleeping? If so, what trouble?	☐ Yes	☐ No
Do you snore?	☐ Yes	☐ No
Do you fall asleep driving or similar activity?	☐ Yes	☐ No
Do you have trouble walking?	☐ Yes	☐ No
Do you have trouble with you speech?	☐ Yes	☐ No
Do you have frequent dizziness?	☐ Yes	☐ No
Do you have motion sickness?	☐ Yes	☐ No
Do you have double vision?	☐ Yes	☐ No
Have you ever had a stroke?	☐ Yes	☐ No

More on next page

HEMATOLOGIC

Do you bleed or bruise easily? ☐ Yes ☐ No
Do you have anemia (low blood count)? ☐ Yes ☐ No
Do you have a history of B12 deficiency or Iron deficiency? ☐ Yes ☐ No

RHEUMATOLOGIC

Do you have a history of any rheumatologic disease (Lupus, Sjogrens, Rheumatoid) ☐ Yes ☐ No
Do you have arthritis or joint pain/swelling? ☐ Yes ☐ No
Do you have back or neck pain? ☐ Yes ☐ No

DERMATOLOGIC

Do you have any skin problems (rashes, acne, moles, etc)? ☐ Yes ☐ No
Have you had malignant melanoma? ☐ Yes ☐ No
Have you had any other form of skin cancer? ☐ Yes ☐ No

PSYCHOLOGIC

Is stress a major problem for you? ☐ Yes ☐ No
Do you feel depressed? ☐ Yes ☐ No
Do you panic when stressed? ☐ Yes ☐ No
Do you have problems with eating or your appetite? ☐ Yes ☐ No
Do you cry frequently? ☐ Yes ☐ No
Have you ever attempted suicide? ☐ Yes ☐ No
Have you ever seriously thought about hurting yourself? ☐ Yes ☐ No
Do you have trouble sleeping? ☐ Yes ☐ No
What degree of stress do you have:
At Home? ____________________
At Work? ____________________
Other? ____________________

WOMEN ONLY-GENITOURINARY

Number of pregnancies _____ Number of live births _____
Have you ever had a miscarriage (in which month did it happen)? ☐ Yes ☐ No
Are you pregnant or breastfeeding? ☐ Yes ☐ No
Have you had a hysterectomy? ☐ Yes ☐ No
Have you had any bladder problems in the past year? ☐ Yes ☐ No
Any problems with control of urination? ☐ Yes ☐ No
Have you had kidney disease? ☐ Yes ☐ No

MEN ONLY-GENITOURINARY

Do you usually get up to urinate during the night? ☐ Yes ☐ No.....If yes, # of times __________
Do you have any bladder problems? ☐ Yes ☐ No
Any difficulty with erection or ejaculation? ☐ Yes ☐ No
Do you have any prostate problems? ☐ Yes ☐ No
Have you had kidney disease? ☐ Yes ☐ No

DOCTOR'S REVIEW

This form was reviewed with patient.

__________________________________ Physician

_______/_____/_____ Date