Northwest Neurology

Health History Form

Name: _____ Date of Birth: _____ Height: _____ Weight: _____

Reason for visit: _____

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

Neurologic:
Headache
Difficulty swallowing
Difficulty with sleep
Balance difficulty
Numbness/Tingling
Weakness
Dizziness
Memory loss
Seizures
Tremor

Genitourinary
Difficulty urinating
Frequent urination
Painful urination
Urinary incontinence
Kidney stone

Musculoskeletal
Pain in arms or legs
Joint pain
Muscle aches/cramps

General
Excessive thirst
Loss of appetite
Fatigue
Fevers
Night sweats
Weight change

ENT
Decreased hearing
Sinus problems
Ringing in ears
Swollen glands
Nose bleeds

Ophthalmologic
Double vision
Visual field loss
Blurred vision

Cardiovascular
Chest pain
Irregular heart beat
Palpitations

Gastrointestinal
Abdominal pain
Constipation
Diarrhea
Nausea
Vomiting

Endocrine
Irregular menses

Respiratory
Shortness of breath
Wheezing
Cough

Psychiatric
Anxiety
Depression
Hallucinations

Other:
_____
_____
_____
_____
_____

Medications: *(Please list all of your current medications)*

Name of Medicine	Dose	Frequency

Name of Medicine	Dose	Frequency

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

_____

_____

Allergies: *(Please list any allergies and the type of reaction you have)*

Substance / Medication	Reaction

Substance / Medication	Reaction

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Northwest Neurology

Past Medical History: *(Please circle if you have had any condition in your past medical history)*

Neurological
Seizures/epilepsy
Multiple Sclerosis
Parkinson's
Dementia
Stroke or TIA
Aneurysm
Head injury
Neuropathy
Myasthenia Gravis
Cluster headaches
Migraines
Abnormal MRI

General
Kidney disease
Hypo or Hyper thyroid
COPD
High blood pressure
High cholesterol
Liver disease
Diabetes

Psychiatric
Anxiety
Depression
Psychosis

Rheumatological
Arthritis
Lupus
Sjogren's
Scleroderma
Autoimmune disease

Ophthalmologic
Glaucoma
Macular Degeneration
Optic Neuritis

Cancer
(If yes specify):
_____

Gastrointestinal
Ulcers
Barrett's esophagus
Gastritis
Diverticulitis
Colonic polyps

Infectious Disease
HIV/AIDS
Tuberculosis
Syphilis
Shingles
Lyme Disease

Cardiovascular
Angina
Heart attack
Pacemaker
Arrhythmia

Sleep
Sleep apnea
Restless legs
Insomnia

Other:
_____
_____
_____

Have you had any falls in the last year? □ Yes □ No If yes, how many? _____ Any Injury? _____

Hospitalizations & Surgeries: *(Please list any recent hospitalizations or surgeries, the location and approximate date)*

Surgery / Hospitalization	Location	Month/Year

Surgery / Hospitalization	Location	Month/Year

Family History: *(Please check the box if anyone in your family has had any of the following conditions)*

Family Member	Diabetes	High Blood Pressure	Heart Disease	Stroke	Mental Illness	Cancer	Unknown	Other
Mother								
Father								
Brother								
Sister								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								

Neurological Family History: *(Please check the box if any of the following neurological conditions run in your family)*

Brain Aneurysm	□	Muscular Dystrophy	□	Neuropathy	□	Migraine	□
Seizures/Epilepsy	□	Multiple Sclerosis	□	Parkinson's Disease	□	Dementia	□

Tobacco Status:
Do you currently smoke cigarettes? □ Yes □ No If yes, how many packs/day? _____
Have you ever smoked cigarettes? □ Yes □ No If yes, when did you quit? _____