TEXAS NEURODIAGNOSTIC, HEADACHE & SLEEP DISORDERS CENTER, P.A.
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NOTE: This is a confidential record of your medical history. Information contained here will not be released to any person without permission.

TODAY'S DATE: _____

CLINICAL INFORMATION

NAME _____ AGE _____ DATE OF BIRTH _____

OCCUPATION _____

MARRIED: _____ WIDOW: _____ DIVORCED: _____ SEPARATED: _____ SINGLE: _____

WITH WHO DO YOU LIVE? _____

REASON FOR CONSULTATION AND/OR CHIEF COMPLAINT:

1. _____

2. _____

3. _____

CURRENT DISEASES (such as diabetes, high blood pressure, thyroid disease, other conditions):

_____

_____

_____

DOCTORS TREATING YOU AT THE PRESENT TIME: _____

_____

_____

CURRENT MEDICATIONS INCLUDING OVER THE COUNTER MEDICATIONS, "NATURAL PRODUCTS, HERBS, ETC."

_____

_____

_____

_____

PLEASE **CIRCLE ALL ANSWERS NO OR YES** If YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING. IF YOU WERE NEVER TOLD YOU HAD ANY OF THE FOLLOWING, CIRCLE NO. A GOOD MEDICAL HISTORY IS NECESSARY FOR A GOOD MEDICAL DIAGNOSIS AND TREATMENT.

NEUROPSYCHIATRIC

1.	Frequent headaches	no	yes	48.	Neuralgia	no	yes
2.	Throbbing headaches	no	yes	49.	Neuritis	no	yes
3.	Syncope (Loss of consciousness)	no	yes	50.	Lack of bladder control	no	yes
4.	Convulsions	no	yes	51.	Lack of rectal control	no	yes
5.	Meningitis	no	yes	52.	Other neurological disorder	no	yes
6.	Encephalitis	no	yes	53.	Birth defects	no	yes
7.	Brain cysticercosis	no	yes	54.	Speech defects	no	yes
8.	Severe fatigue	no	yes	56.	Memory problems	no	yes
9.	Myasthenia gravis	no	yes	57.	Difficulty in swallowing	no	yes
10.	Parkinson's disease	no	yes	58.	Difficulty in talking	no	yes
11.	Multiple sclerosis	no	yes	59.	Difficulty in understanding	no	yes
12.	Involuntary movements	no	yes	60.	Difficulty in writing	no	yes
13.	Torticollis	no	yes	61.	Difficulty in reading	no	yes
14.	Stroke	no	yes	62.	Recent difficulty in dressing	no	yes
15.	Paralysis	no	yes	63.	Disorientation (Do you get lost?)	no	yes
16.	Inability to talk/comprehend	no	yes	64.	Nervousness	no	yes
17.	Head trauma	no	yes	65.	Do you worry a great deal?	no	yes
18.	Brain bleeding (hematoma)	no	yes	66.	Do you repeat things over and over?	no	yes
19.	Brain aneurysm	no	yes	67.	Do you think about the same subject over and over?	no	yes
20.	Brain tumor	no	yes	68.	Are you a perfectionist?	no	yes
21.	Brain surgery	no	yes	69.	Fear, phobia of people, animals, places, situations	no	yes
22.	Spine surgery	no	yes	70.	Fear of being in closed spaces (claustrophobia)	no	yes
23.	Arterial surgery	no	yes	71.	Diseases without any physical cause	no	yes
24.	Myelog ram	no	yes	72.	Learning disabilities	no	yes
25.	Electroencephalogram	no	yes	73.	Depression	no	yes
26.	Electromyogram	no	yes	74.	Episodes of feeling high	no	yes
27.	Arteriogram, angiogram, DSA	no	yes	75.	Bipolar disorder	no	yes
28.	Brain scan	no	yes	76.	Stress	no	yes
29.	Brain or spine MRI	no	yes	77.	Nervous breakdown	no	yes
30.	Spine x-rays	no	yes	78.	Do you hear voices?	no	yes
31.	Brain or spine radiation	no	yes	79.	Do you see visions?	no	yes
32.	Brain biopsy	no	yes	80.	Do you perceive smells that other people do not?	no	yes
33.	Muscular weakness	no	yes	81.	Do you see flashes of light?	no	yes
34.	Weakness in arms	no	yes	82.	Do you have ideas that somebody is against you?	no	yes
35.	Weakness in legs	no	yes	83.	Personality change	no	yes
36.	Difficulty in walking	no	yes	84.	Do you prefer to be alone?	no	yes
37.	Incoordination	no	yes	85.	Are you an optimist?	no	yes
38.	Cramps	no	yes	86.	Are you a pessimist?	no	yes
39.	Poliomyelitis	no	yes	87.	Do you feel aggressive?	no	yes
40.	Persistent neck pain	no	yes	88.	Are you violent towards other people?	no	yes
41.	Pain in the upper back	no	yes	89.	Do you wish to die?	no	yes
42.	Pain in the lower back	no	yes	90.	Suicidal ideas	no	yes
43.	Pain in the face	no	yes	92.	Homicidal ideas or attempts	no	yes
44.	Pain in arms and legs	no	yes				
45.	Pain in the hands or feet	no	yes				
46.	Numbness in hands at night	no	yes				
47.	Numbness as sensation of pins & needles	no	yes				

93. Anorexia, bulimia no yes
94. Psychiatric treatment, electroshock, tranquilizers, no yes
95. Treatment with lithium no yes

96. Do you use or have you used illegal drugs? no yes
Which _____
Last time _____
97. Do you drink? no yes
How much? _____
98. Do you smoke? no yes
How much _____
99. Heavy coffee or tea drinker? no yes
100. Sexual problems or disorders no yes

SENSE ORGANS

101. Eye disease no yes
102. Blurred vision no yes
103. Glaucoma no yes
104. Double vision no yes
105. Retinal detachment no yes
106. Eyelid drop no yes
107. Eyesight worsening no yes
108. Sudden lack of vision in one or both eyes? no yes
109. Change in sense of smell
110. Change in taste no yes
111. Hearing difficulties no yes
112. Buzzing in the ears no yes
113. Dizziness no yes
114. Vertigo (spinning sensation) no yes
115. Sinus infections/sinusitis no yes
116. Congested or runny nose no yes
117. Nose bleeds no yes
118. Frequent sore throats no yes

SLEEP DISORDERS

119. Insomnia no yes
120. Difficulty falling asleep no yes
121. Difficulty in maintaining asleep no yes
122. Waking up early in the morning no yes
123. Snoring no yes
124. Sleep apnea (Do you stop breathing at night?) no yes
125. Chocking or gasping for air while sleeping no yes
126. Do you have headaches in the morning when you awake? no yes
127. Restless sleep no yes
128. Do you fall asleep while driving? no yes
129. Do you hear voices while falling asleep? no yes
130. Do you fall often? no yes
131. Do things fall from your hands? no yes
132. Are you sleepy during the daytime? no yes
133. Do you kick at night? no yes
134. Do you toss in bed? no yes
135. Urge to move the legs or to walk while falling asleep no yes
136. Nightmares no yes
137. Do you regurgitate food while sleeping? no yes
138. Excessive daytime sleep no yes
139. Sleep walking no yes
140. Sleep talking no yes
141. Sensation of paralysis while sleeping? no yes
142. Do you have shift work? no yes

RESPIRATORY

143. Cough up phlegm no yes
144. Cough up blood no yes
145. Tuberculosis no yes
146. Fever in the evenings no yes
147. Sweating at night no yes
148. Emphysema no yes
149. Bronchitis no yes
150. Asthma no yes
151. Pneumonia no yes

CARDIOVASCULAR

152. Palpitations no yes
153. Chest pain no yes
154. Shortness of breath no yes
155. Swollen feet or ankles no yes
156. High blood pressure no yes
157. Low blood pressure no yes
158. Heart attack no yes
159. Heart arrhythmia no yes
160. Do you need to sit up while sleeping? no yes
161. Rheumatic fever no yes
162. Pacemaker no yes
163. Heart surgery no yes

GASTROINTESTINAL

164. Heartburn, stomach pain no yes
165. Bloating, abdominal stomach distention no yes
166. Stomach or duodenal ulcer no yes
167. Frequent diarrhea no yes
168. Colic pain no yes
169. Rectal bleeding no yes
170. Vomiting blood no yes
171. Poor appetite no yes
172. Constipation no yes
173. Are you on a diet? no yes
174. Are you losing weight? no yes
175. Are you gaining weight? no yes
176. Intestinal parasites no yes

177.	Colitis	no	yes
178.	Diverticulosis	no	yes
179.	Pancreatitis	no	yes
180.	Hemorrhoids		
181.	Inguinal hernia	no	yes
182.	Hiatal (diaphragmatic) hernia	no	yes
183.	Liver disease (hepatitis)	no	yes
184.	Jaundice	no	yes
185.	Liver cirrhosis	no	yes

KIDNEY URINARY

186.	Urinary retention	no	yes
187.	Urination without control	no	yes
188.	Frequent urination	no	yes
189.	Burning on urination	no	yes
190.	Bloody urine	no	yes
191.	Kidney or bladder disease	no	yes
192.	Urinary stones	no	yes
193.	Gonorrhea	no	yes
194.	Syphilis	no	yes
195.	Do you think you might be a risk of having AIDS?	no	yes
196.	Other veneral disease	no	yes

FOR MALES ONLY (#197.200)

197.	Prostate problems	no	yes
198.	Testicular inflammation	no	yes
199.	Undescended testicles	no	yes
200.	Inflammation of penis	no	yes

FOR FEMALES ONLY (# 201.218)

201.	Menstrual irregularities	no	yes
202.	Heavy bleeding	no	yes
203.	IUD	no	yes
204.	Birth control pills, injections or implants	no	yes
205.	Pregnancy	no	yes

How many? _____

206.	Normal deliveries	no	yes
207.	Abortions or miscarriages	no	yes
208.	C-sections	no	yes
209.	Vaginal discharge	no	yes
210.	Breast discharge	no	yes
211.	Pap smear	no	yes

Date of last one _____

212.	Breast tumors	no	yes
213.	Breast biopsy	no	yes
214.	Last period	no	yes

Date _____

215.	Are you pregnant?	no	yes
216.	Do you have children?	no	yes
217.	Have any of them died?	no	yes

How many _____

218.	Have any of them had serious medical problems? If yes, which _____	no	yes

HEMATOLOGIC ONCOLOGIC

219.	Cancer or tumor	no	yes
220.	Chemotherapy	no	yes
221.	Radiation therapy	no	yes
222.	Leukemia	no	yes
223.	Anemia	no	yes
224.	Bleeding tendencies	no	yes
225.	Blood transfusions	no	yes

ENDOCRINE

226.	Thyroid disease	no	yes
227.	Do you often feel cold?	no	yes
228.	Parathyroid disease	no	yes
229.	Diabetes	no	yes
230.	Hypoglycemia	no	yes
231.	Cold or sweating episodes	no	yes
232.	Adrenal gland disease	no	yes

OTHER

233.	Porphyria	no	yes
234.	Lupus	no	yes
235.	Other collagen disease	no	yes
236.	Dry eyes or mouth	no	yes
237.	Arthritis	no	yes
238.	Gout	no	yes
239.	Skin diseases	no	yes
240.	Skin allergies	no	yes
241.	Swollen or painful tongue	no	yes
242.	Mouth infections or ulcers	no	yes
243.	Febrile diseases	no	yes
244.	Malaria	no	yes
245.	Other diseases	no	yes

ACCIDENTS

246.	At work	no	yes
247.	At home	no	yes
248.	Other places	no	yes
249.	Bone fractures	no	yes

ALLERGIES

Are you allergic to:

1. Food? no yes

Which ones? _____

_____

2. Medications? no yes

Which ones? _____

_____

3. Iodine? no yes

4. Shrimps? no yes

5. Have you ever had an injection with iodine for an arteriogram (angiogram) CAT scan, kidney examination of gallbladder exams? no yes

HOSPITAL ADMISSIONS:

Reason for hospitalization Name of hospital Doctors name Date

OPERATIONS OR BIOPSIES

Spine _____	Date: _____	Where: _____	Surgeon: _____
Head _____	Date: _____	Where: _____	Surgeon: _____
Neck _____	Date: _____	Where: _____	Surgeon: _____
Eyes _____	Date: _____	Where: _____	Surgeon: _____
Ears _____	Date: _____	Where: _____	Surgeon: _____
Thyroid _____	Date: _____	Where: _____	Surgeon: _____
Chest _____	Date: _____	Where: _____	Surgeon: _____
Heart _____	Date: _____	Where: _____	Surgeon: _____
Stomach _____	Date: _____	Where: _____	Surgeon: _____
Gallbladder _____	Date: _____	Where: _____	Surgeon: _____
Intestines _____	Date: _____	Where: _____	Surgeon: _____
Appendix _____	Date: _____	Where: _____	Surgeon: _____
Genital Organs _____	Date: _____	Where: _____	Surgeon: _____
Prostate _____	Date: _____	Where: _____	Surgeon: _____
Uterus _____	Date: _____	Where: _____	Surgeon: _____
Ovaries _____	Date: _____	Where: _____	Surgeon: _____
Hernia Repair _____	Date: _____	Where: _____	Surgeon: _____
Bladder _____	Date: _____	Where: _____	Surgeon: _____
Breasts _____	Date: _____	Where: _____	Surgeon: _____
Other _____	Date: _____	Where: _____	Surgeon: _____

Have you ever been advised to have surgery or a biopsy and you refused it? no yes

FAMILY HISTORY	**IF LIVING**		**IF DECEASED**	**CAUSE OF DEATH**
Relative	Age	Health	Age at time of death	
Father				
Mother				
Brother/Sister 1				
2				
3				
Husband/Wife				
Son/Daughter 1				
2				
3				

HAS ANY RELATIVE EVER HAD:	Circle No or Yes		WHO?
Cancer	no	yes	
Tuberculosis	no	yes	
High Blood Pressure	no	yes	
Heart Trouble	no	yes	
Stroke	no	yes	
Diabetes	no	yes	
Epilepsy	no	yes	
Mental Disorder	no	yes	
Suicide	no	yes	
Migraines	no	yes	
Muscular Disease	no	yes	
Neuropathy	no	yes	
Paralysis	no	yes	
Huntington's Chorea	no	yes	
Wilson's Disease	no	yes	
Others	no	yes	

MARITIAL AND SEXUAL

Relationship with husband/Wife: _____

Describe his/her personality: _____

Is your wife / husband employed? _____Where _____

Three things that you like most about your husband / wife.

1. _____
2. _____
3. _____

Three things that you dislike most about your husband / wife.

1. _____
2. _____
3. _____

Spouse's age at time of marriage: _____

Date of marriage: _____

Where you previously married? _____

How many times? _____

SEXUAL DEVELOPMENT: (Describe any problems such as decreased sexual drive, potency / frigidity, sexual abuse, other)
_____

SOCIAL HISTORY:
Birthplace: _____ Birth Date: _____
Where reared and by whom: _____
_____
Mother _____ Age: _____
State of Health: _____
Neurological or psychiatric conditions: _____
Occupation: _____
Relationship and Description: _____
Father _____ Age: _____
State of Health: _____
Neurological or psychiatric conditions: _____
Occupation: _____
Relationship and Description: _____
Brother _____ Age: _____
State of Health: _____
Neurological or psychiatric conditions: _____
Occupation: _____
Relationship and Description: _____
Sister _____ Age: _____
State of Health: _____
Neurological or psychiatric conditions: _____
Occupation: _____
Relationship and Description: _____

PHYSICAL / PSYCHOLOGICAL ABUSE: In childhood? _____ Adolescence? _____ In adulthood? _____
Relationship with children: _____
Other important persons in your life: _____
Serious difficulties: _____
Big crisis in your life (illness, accidents, severe problems, sexual abuse, problems with self or relatives, physical or psychological abuse) _____
_____

EDUCATION:
Grade completed / Where: _____
Age completed: _____ Reason for leaving: _____
Relationship with Teachers / Students: _____
Socialization Achievements: _____
Serious Difficulties in School: _____
Additional Training or Studies: _____

MILITARY:
Age entered: _____ Date discharged: _____ Branch: _____
Type of Discharged: _____ Highest Rank: _____
Adjustments: _____

PROBLEMS WITH THE LAW (POLICE):
When: _____ Offense: _____ Convicted: _____
Sentence: _____

RELIGION: _____

EMPLOYMENT:

Present: _____
Longest Employment Period: _____
Highest Salary: _____ Relationship with Supervisors / Co-Workers: _____
_____

SELF CONCEPT:

A. What do you like about yourself? _____
_____
B. What do you dislike about yourself? _____
_____
Do you think life is worth living? _____
_____
Your plans for the future: _____
_____
Spare time activities: _____
_____
How do you feel more relaxed? _____
_____
How do you feel more tense? _____
_____

_____
Your signature, please