CLINICAL NEUROLOGY

NEW PATIENT HISTORY FORM

Name: ______________________ Birth Date: ______________________

Address: ______________________ Occupation: ______________________

______________________ Weight Now: ________ One Year Ago: _______ Height: ________

Describe your main complaint: ______________________

Family History:

How many brothers _______? Sisters _______?	**father**	**Mother**	**brothers (1.2.)**	**Sisters (1.2.)**
Age (if living; or at death)				
Health (good or bad)				
Epilepsy, seizures				
Multiple sclerosis				
Muscular dystrophy				
Nervous breakdown				
Migraine or severe headaches				
Memory loss				
Tremor or shaking				
Trouble walking				
Mental retardation				
Cause of death or deceased				
Other inherited condition (Explain)				

your personal history:

	No	**yes**
Married / Years _______		
Number of children _________		
Rheumatic fever, heart disease		
Arthritis; Rheumatism		
Bone or joint disease		
Neuritis; Neuralgia		
Bursitis; Sciatica; Lumbago		
Polio; Meningitis		
Gonorrhea; Syphilis		
Anemia; Jaundice		
Tuberculosis		
Diabetes		
Cancer		

	No	**Yes**
High Blood Pressure		
Blackouts		
Epilepsy, seizures		
Migraine Headaches		
Nervous Breakdown		
Asthma		
Broken bones		
Concussion; Head injury		
Skin rashes		
Glaucoma		
Exposure to toxins		
Exposure to lead		
Ulcers		

Are you right or left handed. — Please circle one

your allergies:

	No	**yes**
Penicillin		
Sulfa		
Aspirin		
Codeine, Morphine		
Mycins, Other antibiotics		

	No	**Yes**
Tetanus		
Other drugs ____________		
____________		
Foods ____________		
Other (Pollen, etc.) ____________		
____________		

your surgery:

	No	**yes**
Tonsils, appendix, gallbladder		
Hysterectomy		
Disc, Pinched nerve		
Brain		
Blood Transfusion(s)		

	No	**Yes**
Other surgery		
____________		
Other hospitalizations		
____________		
____________		

please use additional page for any additional information
please also complete the reverse of this form

OVER →

Name: ______________________________

your x-rays, tests:

	No	yes	date	result
Chest				
Neck				
CT Neck or Back				
CT Head or Brain				
MRI Neck or Back				
MRI Head				
Myelogram				
EKG (cardiogram)				
EEG (brainwave)				

systems: Do you have:

	No	yes
Eye disease or injury		
Vision loss, temporary or permanent		
Ear disease or injury		
Fainting spells		
Convulsions or seizure		
Paralysis, temporary or permanent		
Dizziness		
Numbness, part of the body		
Headaches, frequent or severe		
Tick bites		

	No	Yes
Chest pain		
Shortness of breath		
Palpitations, heart flutter		
Extreme daytime fatigue		
Kidney disease		
Trouble urinating		
Stomach ulcer		
Liver Disease		
Change in appetite		
Dry eyes or mouth		

habits: Do you:

	No	yes
Exercise adequately?		
How?		
Fall asleep during the day?		
Awaken rested?		
Sleep well?		
Average hours sleeping ____________ : _____		
Like your work?		
Vacation _______ weeks per year		
Ever been treated for alcoholism?		
Ever been treated for drug abuse?		

Do you use:

	No	Yes
Vitamins?		
Sedatives?		
Tranquilizers?		
Sleeping pills?		
Aspirin or Tylenol?		
Alcohol: _______ drinks weekly		
Coffee, tea, cola with caffeine: _____ daily		
Cigarettes: _______ packs/day		
for _______ years		

medications: Please List all medicines you regularly take.

Name of Drug	Dosage of pill	When do you take them?	Total, how many daily?

Emotions: Are you often

	No	yes
Depressed?		
Anxious?		
Irritable?		
Feeling helpless?		

Are you often

	No	Yes
Jumpy?		
Jittery?		
Feeling hopeless?		
Have trouble concentrating?		

women only:

	No	yes
Regular menstrual periods?		
Tension or depression before?		
Cramps, pain, or headache before?		

Cycle (start to start) .... ________ days

Date last menstrual period began .... ______

Number of children born alive .... ______

Number of Caesarian sections .... ______