

**INFORMATION FOR YOUR PHYSICIAN**

**TODAY'S DATE** \_\_\_\_\_ **PATIENT NAME** \_\_\_\_\_

**I. CHIEF COMPLAINT**

*Please write the reason you came to the doctor at this time:* \_\_\_\_\_

*What is your main symptom?* \_\_\_\_\_

*When did your symptoms start?* \_\_\_\_\_

*Have you had a previous neurological evaluation and, if so, what is the doctor's name?* \_\_\_\_\_

*Are you seeing us about a motor vehicle accident injury or a work-related injury?* Yes/No

*If yes, date of accident/injury* \_\_\_\_\_

**II. PAST MEDICAL HISTORY**

*Please circle illnesses or conditions **YOU** have had:*

- |              |              |                        |                 |                     |
|--------------|--------------|------------------------|-----------------|---------------------|
| Diabetes     | Glaucoma     | Heart Trouble          | Syphilis        | Mental Illness      |
| Cancer       | Asthma       | Liver disease/Jaundice | Gonorrhea       | Bleeding Tendencies |
| Tuberculosis | Pneumonia    | Kidney Disease         | Rheumatic Fever | HIV/AIDS            |
|              | Hypertension | Muscle/Nerve Disorder  | Headache        |                     |

**Other:** \_\_\_\_\_

*Please list other illnesses not requiring operation for which you were hospitalized:*

\_\_\_\_\_

*Have you had serious injuries, broken bones, etc.? If so, list:* \_\_\_\_\_

*Have you received a blood transfusion?* Yes/No      *Date(s):* \_\_\_\_\_

*Your weight dressed:* \_\_\_\_\_      *Are you taking oral contraceptives?* \_\_\_\_\_

*Menstrual History:* Last period \_\_\_\_\_ (date of onset).      Periods are \_\_\_\_\_ regular \_\_\_\_\_ irregular.

**III. SURGICAL HISTORY**

*Please list, giving dates, hospital where performed and name of surgeon:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IV. FAMILY HISTORY**

*Please circle illnesses which have occurred in any of your **blood relatives**:*

- |                       |               |                |              |
|-----------------------|---------------|----------------|--------------|
| Bleeding Tendency     | Diabetes      | Kidney Disease | Tuberculosis |
| High Blood Pressure   | Heart Disease | Mental Illness | Allergy      |
| Muscle/Nerve Disorder | Headache      | Cancer         | Stroke       |

**Other:** \_\_\_\_\_

	Living	Age or Age at Death	Present Health or Cause of Death
Father	Yes/No	_____	_____
Mother	Yes/No	_____	_____
Brothers	No. Living	_____	Health _____
	No. Dead	_____	Cause of Death _____
Sisters	No. Living	_____	Health _____
	No. Dead	_____	Cause of Death _____
Children Living	_____	Ages and Health _____	
Children Dead	_____	Ages and Cause _____	

**V. MEDICATIONS**

*Please name or otherwise identify medicines now or recently used* \_\_\_\_\_

**VI. ALLERGIES**

*List medications or substances to which you have had allergy or sensitivity:*

*Please describe the allergy/sensitivity:* \_\_\_\_\_

**VII. SOCIAL HISTORY**

Age \_\_\_\_\_ Place of birth \_\_\_\_\_ Race/Nationality/Ethnic Background \_\_\_\_\_

(for hereditary diseases)

Education \_\_\_\_\_ Age on completion \_\_\_\_\_

(highest level attained)

Occupation \_\_\_\_\_ How long \_\_\_\_\_ Maiden name \_\_\_\_\_

Where and when have you lived or traveled outside of the U.S. or Canada? \_\_\_\_\_

Do you use tobacco now? \_\_\_\_\_ In the past? \_\_\_\_\_ Type and amount \_\_\_\_\_

Do you use alcoholic beverages? \_\_\_\_\_ Type \_\_\_\_\_ Weekly amount \_\_\_\_\_

Do you use recreational or illegal drugs? \_\_\_\_\_ Type and amount \_\_\_\_\_

Spouse living? Yes/No \_\_\_\_\_ Health/Cause of death \_\_\_\_\_

Present marriage - years \_\_\_\_\_ Previous marriage - year and duration \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

Reviewed by \_\_\_\_\_  
(Physician)

Date \_\_\_\_\_