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: _____

(OVER)

	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 _____ (highest level attained) Age on completion _____

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 _____ **Date** _____

(Physician)