HUMBOLDT NEUROLOGY PATIENT HISTORY

Today's Date: _____

Patient Name: _____ **Birthdate**: _____

Height:_____ Weight:_____ Reason for visit:_____

Family History: For each of the following, please mark an 'X' for each relative who has suffered from the condition.

	Brother/Sister	Mother	Father	Grandmother	Grandfather
Alzheimers/Dementia	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Migraine headaches	_____	_____	_____	_____	_____
Neuropathy	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Other neurological disease	_____	_____	_____	_____	_____

(Please Specify: _____)

Current Medication	**Dosage**	**Reason forTaking**	**Medical Problems, Surgery, Hospitalizations**	**Year**
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	

Do you have Drug Allergies? (List meds):_____

Do you have Adaptive Equipment? Cane____ Walker____ Wheelchair ____ CPAP____ Other:_____

Review of Systems: Circle all of the following problems that you are currently suffering.

Anemia	Cold numb feet	Fever	Memory loss	Sleeping difficulty
Arthritis/Rheumatism	Depression/Anxiety	Headaches-migraine	Mental illness	Spasticity
Asthma/Wheezing	Diabetes	Headaches-severe	Moodiness	Stroke
Back pain-frequent	Dizziness	Heart palpitations	Muscle weakness	Swallowing difficulty
Bladder problems	Double/Blurred vision	High blood pressure	Night Sweats	Thyroid disease
Bowel problems	Fainting spells	High cholesterol	Numbness	Tingling sensations
Bruise easily	Falling	Irregular Pulse	Seizures/Convulsions	Tremor/Hands shaking
Calf pain-walking	Fatigue-loss of energy	Lightheadedness	Sleep Apnea	Weight gain/Weight loss

Cancer (type_____) Other Symptoms:_____

Persons Age 65 or older: Do you have a healthcare surrogate or Advanced Care Directive? _____

Habits Do you smoke? YES NO If Yes, # packs/day?_____ If No, have you ever smoked? _____

Do you drink alcohol? YES NO If Yes, # drinks/week?_____ Do you drink caffeine? YES NO If Yes, # cups/day? _____

Do you exercise? YES NO If Yes, what type of exercise?_____ How Often?_____