

Stillwater Medical Group - Neurology History Form

Welcome to our neurology clinic! The nervous system is very complex, and to serve you better, it's important that I learn about your medical history, both problems you have now and medical problems you've had in the past. Thank you very much for your patience in filling out this form before your appointment, even if this information is already in your chart.

Name _____ Date of Birth _____ Today's date _____

Who referred you to a neurologist? _____

Name of your primary care physician: _____

Which hand do you use most or dominantly? (circle) Right Left Ambidextrous

1. Please describe in detail, the problem or symptoms for which you're being seen today by the neurologist. (symptoms you're having, what body part it affects, how often it happens, how severe, etc.)

Physician Notes

Copies of note to:

2. When did this problem start (date) and how old were you then?

3. Is there anything that triggered this problem?

4. Does anything make this problem better?

5. Describe any of the following treatments you've tried and did they work?

Self care you've tried:

Medications:

Physical Therapy:

Surgery:

Other treatments (e.g. chiropractic or other):

4. What diagnostic tests have been done so far? (e.g. blood work, MRI, EMG, EEG, etc.)

6. Have you seen a neurologist before for this problem? If so, what is the neurologist's name/location? _____

7. Date(s) you saw this doctor: _____

Please do not write in this space.

Past Medical History: Please check if you've ever had any of these **neurological or muscle illnesses:**

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Spells of loss of consciousness | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> TIA (stroke that 'went away') | |
| <input type="checkbox"/> Carotid stenoses | <input type="checkbox"/> Brain aneurysm | <input type="checkbox"/> Bleeding in or around the brain |
| <input type="checkbox"/> Brain surgery | <input type="checkbox"/> Brain tumor | <input type="checkbox"/> Brain radiation treatments |
| <input type="checkbox"/> Carotid or other dissection | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Vision loss or optic neuritis |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Head injury | <input type="checkbox"/> Other neurologic infections |
| <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Tremors | <input type="checkbox"/> Sleep disorders |
| <input type="checkbox"/> Muscle diseases | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Problems with walking |
| <input type="checkbox"/> Genetic or inherited neurologic disease | | <input type="checkbox"/> neuromas or neurofibromas |

Have you had any neurological or muscular illness not listed above?

Other Past Medical History: Please check if you have ever had ...

Medical problems you were born with (congenital), please describe

Cardiac or vascular diseases including: Heart trouble

- High blood pressure High cholesterol
- Other clogged arteries (peripheral vascular disease)
- Atrial fibrillation
- Other heart or vascular problems (describe) _____

Metabolic diseases including: diabetes thyroid disease

- kidney disease liver disease B12 deficiency
- other metabolic diseases (describe): _____

Cancer, please describe: _____

Other tumors, please describe: _____

Infections, including: meningitis encephalitis cold sores

- genital herpes shingles sinus infections
- other infections (describe): _____

Childhood infections including: measles mumps

- chicken pox rheumatic fever
- Immunizations including: polio Lyme tetanus (date _____)

Degenerative diseases including: arthritis lupus

Other degenerative diseases (describe): _____

Other illnesses not listed above (describe) _____

Surgical operations, please describe: _____

Injuries, car accidents, & broken bones (describe and list date) _____

Please do not write in this space.

Have you ever been hospitalized for any reason? ____yes ____no

Please describe reason for all hospitalizations:

Have you ever been treated for depression, anxiety, or chemical dependency issues? Please describe and give dates of treatment..

Do you have any difficulties with thought disorders such as hallucinations, schizophrenia, etc.? Please describe.

Please do not write in this space.

MEDICATIONS: Please list all the prescription medications, vitamin and other supplements, and herbal medications you take now.

Medication	Dose / how often	Medication	Dose / how often
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

Drug Allergies or Reactions to medications: Please list any medications to which you've got an allergy or had bad reaction:

FAMILY HISTORY: Does anyone else in your family have a similar problem to one you are being seen for today?

Please fill in the health history of your blood relatives below:

Relation	Are they Alive?		Age	Health problems
	Yes	No		
Mother				
Father				
Brother or Sister				
Brother or Sister				
Brother or Sister				
Brother or Sister				
Brother or Sister				
Brother or Sister				
Brother or Sister				
Son or Daughter # 1				
Son or Daughter # 2				
Son or Daughter # 3				
Son or Daughter # 4				
Son or Daughter # 5				

Please
do not
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SOCIAL HISTORY:

Are you ___single ___married ___partnered ___divorced ___widowed?
 If applicable, how many years have you been or were you married? _____
 Number of children and ages: _____
 What is your occupation? _____
 Education: list highest grade/degree attended: _____
 Have you ever smoked or chewed? ___yes ___no What age did you start? _____
 Do you currently smoke or chew? ___no, I quit (date) _____. ___yes How much per day? _____
 How much alcohol do you drink per week? _____
 Have you ever used street drugs or drugs not prescribed to you? _____
 What are your significant hobbies or interests? _____

REVIEW OF SYSTEMS: Please circle problems you have now or had recently

Neurological: Memory loss, word finding problems, getting lost frequently, difficulty doing tasks you could do previously, seizures, loss of consciousness, loss of sense of smell, double vision, dizziness, tinnitus or ringing in your ears, problems with hearing, slurred speech, problems chewing or swallowing, change in sense of taste, weakness in part of your body, numbness, incoordination, falls, loss of balance, pain or tingling, difficulty walking, muscle stiffness, muscle cramps, tremor, problems controlling movement, muscle jerks or twitches

Ocular: decreased vision, double vision, pain in eyes.

Autonomic: dry eyes, dry mouth; *any of these changes when you stand up:* dizziness, weakness, fatigue, mental changes, visual changes, vertigo, anxiety, heart palpitations, nausea, fainting

Blood disorders: anemia, bruising, bleeding gums, recurrent infections, etc.

Heart: heart attacks, chest pain, shortness of breath, swollen feet, light-headedness, palpitations, atrial fibrillation, etc.

Lungs: shortness of breath, spitting up blood, painful breathing, increased phlegm.

Gastrointestinal: *any of these changes after eating:* early fullness, bloating, nausea, dizziness, sweating.

Any time: abdominal pain, vomiting blood, dark/tarry bowel movements, heartburn, diarrhea, constipation;

Urinary / kidneys: incomplete emptying of your bladder, difficulty starting the stream, losing urine (incontinence), being unable to go/painful urination, blood in urine, pus in urine, previous history of bladder disease, kidney disease.

Sexual: inability to get an erection, difficulty achieving orgasm, retrograde ejaculation (painful ejaculation back into the bladder)

Endocrine: diabetes, thyroid disease, B12 deficiency, adrenal insufficiency, hypertension, problems with calcium metabolism, pituitary problems, excessive thirst,

Skin: rashes, sores, unusual spots or patches of color, skin cancer, melanoma, new lumps or bumps, changes in skin appearance that come and go

Musculoskeletal: joint pain, muscle pain, joint deformities, frequent fractures, arthritis

Allergic/Immune: allergies, hay fever, sinus problems, frequent infections

Ears, nose, throat: sinus disease, decreased hearing, vertigo, ringing in ears, sores in mouth, nasal polyps

Psychiatric: anxiety, depression, hallucinations, violent behavior

Constitutional: unexplained weight gain or loss, fever, chills, fatigue, sweats,

All of these
systems
reviewed, and
unless circled
are negative or
noncontributory