Mary Washington Neurology

Patient History Form

Name: ________________________ Age: _____Referring Doctor: ________________________

Date: _________________________ Right or Left Handed: _______________________________

Reason for neurological consultation? ____

No.	Past History	Yes	No	
1	Diabetes			**Drug Alergies:**
2	Hypertension			
3	High cholesterol			
4	Cancer			
5	Stroke			
6	Heart trouble/heart attack			
7	Thyroid problems			
8	Arthritis/gout			
9	Convulsions/epilepsy			
10	Bleeding tendency			
11	Acute infections			
12	Venereal disease			
13	Hereditary defects			
14	Allergies			
15	Psychiatric problems			
16	GI/liver disease			
17	Pulmonary disease/pneumonia			
18	HIV testing			**Result:**
Family History - Check YES - Explain above				

☐ Heart disease
☐ Gait disorder
☐ Stroke
☐ Headaches

☐ Neuropathy/numbness
☐ Seizure/epilepsy
☐ Multiple Sclerosis
☐ Hereditary illness

☐ Alzheimers/dementia
☐ Tremor/Parkinsons
☐ Muscle disease/weakness
☐ Other medical illness

Father (Age/Health) ________
Mother (Age/Health) ________
Siblings (Age/Health) _______

Neurological Testing	Yes	No	Date	Result
MRI Scan				
CT Scan				
X-Rays				
Arteriogram/Carotid Ultrasound				
Evoked Potential Studies				
EMG/NCV				
Electroencephalogram (EEG)				

Social History

Occupation: ___________________ Tobacco: (amount) ________________________ Alcohol: (amount)_____________________
Marital Status: Single___ Married ___ Divorced ___ Widowed ___ Children: ____
Exposure to: Fumes ___ Dust ___ Solvents ___ Air-borne particles ___

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Chronic Illnesses	Status	Prior hospitalizations, surgeries, illnesses	Date
1			
2			
3			
4			

Patient Signature ________________ Date ________ MD Signature ________________

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Review of Systems

Please circle any symptoms that are NOW present.

Constitutional Symptoms
- Weight Loss
- Weight Gain
- Appetite Change
- Fever
- Severe Fatigue
- Sleep Disturbance

Eyes
- Glaucoma
- Cataracts
- Changing Vision
- Eye Pain or Redness
- Double Vision
- Visual Loss
- Flashing Lights
- Other _________________

Ears / Mouth / Throat
- Hearing Loss
- Ear Pain
- Ringing in Ears
- Sinus Disease
- Loss of Smell or Taste
- Vertigo (Spinning)
- Swallowing Difficulty
- Hoarseness or Change in Voice
- Swollen Glands
- Sore Throat or Mouth Sores
- TMJ Disorder
- Other _________________

Cardiovascular
- Hypertension (High Blood Pressure)
- High Cholesterol
- Chest Pain or Angina
- Heart Murmur
- Irregular Heartbeat (Palpitations)
- Faintness/Lightheadedness
- Heart Failure
- Other ___________________

Respiratory
- Shortness of Breath
- Cough
- Coughing up Blood
- Asthma/Wheezing
- Other _________________

Gastrointestinal
- Abdominal Pain
- Ulcer Disease
- Gastric Reflux Disorder
- Hepatitis
- Liver Failure
- Blood in Stool
- History of GI Bleeding
- Constipation
- Diarrhea
- Loss of Bowel Control
- Nausea/Vomiting
- Other _________________

Genitourinary
- Blood in Urine
- Pain on Urination
- Frequent Bladder Infections
- Problems Controlling Bladder Function
- Kidney Stones
- Sexual Dysfunction
- Other _________________

  FEMALE: # of Pregnancies ____
  Miscarriages _____
  Last Menstrual Period __________
  Birth Control Pills ___
  Hormone Replacement Therapy ___
  Other ________________________

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Neurological

- Headaches
- Confusion
- Memory Loss
- Change in Speech
- Difficulty Walking
- Weakness all over
- Weakness in Part of Body
  ____________(Where)
- Difficulty with Coordination
- Muscle Pain
- Muscle Spasms or Cramps
- Tremor
- Convulsions/Seizures
- Numbness/Tingling
  __________________(Where)
- Stroke or "TIA"
- Head Injury ("knocked unconscious")
- Other ___________________

Psychiatric

- Nervousness
- Worry
- Depression
- Mood Swings
- Sleep Disturbances
- Panic Attacks
- Hallucinations
- Learning Disabilities
- History of Drug or Alcohol Abuse
- History of Counseling
- Other ________________________

Bones and Joints

- Arthritis
- Swollen Joints
- Gout
- Back Pain
- Neck Pain
- Radiating Pain into Arm __________
- Radiating Pain into Leg __________
- Other ________________________

Skin

- Rash
- Easy Bruising
- Varicose Veins
- Other _________________

Endocrine

- Diabetes
- Thyroid Disease
- Excessive or Decreased Sweating
- Breast Discharge
- Other ____________________

Hematologic

- Anemia
- History of Blood Clots (Phlebitis)
- DVT (Deep Vein Thrombosis)
- Past Transfusions
- Bleeding Disorder
- Other ___________________

Allergy

- List Food Allergies/Reactions
  ____
- _____________________________
- _____________________________
- List Environmental Allergies/Reactions
- _____________________________
- _____________________________
- Allergy Shots? _______________
- Drug/Medication Allergies ________
- _____________________________
- _____________________________