

NeuroScience Associates

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PATIENT HEALTH HISTORY

Patient Name: _____ Today's Date: _____
Date of Birth: _____

Patient Height _____ Patient Weight _____

Chief Complaint

Reason for today's visit? _____

Current problem is the result of a(n): Check all that apply

Car Accident Work Accident Accident Other _____

Date of onset _____

Past History

Please list any prior major illnesses and/or injuries: _____

Surgeries/Hospitalizations	Year	Complications

Have you ever had problems with anesthesia? Yes No

Do you take Aspirin? Yes No If Yes, how often : _____

Current Medications Including Over the Counter	Dose	Frequency

Patient Name: _____ Today's Date: _____
 Date of Birth: _____

ALLERGIES/TYPES OF REACTIONS
Please circle: Latex Yes No Iodine Yes No Shellfish Yes No Asthma Yes No

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

SOCIAL HISTORY

Do you have children? Yes No How many? _____

Do you live alone? Yes No Who lives with you? _____

Do you smoke? Yes, I've smoked _____ packs of cigarettes per day for _____ years.
 Yes, I smoke cigars or a pipe.
 No, I have never smoked.
 No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____ years.

Do you drink alcohol? No, never (or rarely) No, but I used to
 Yes Daily 1 or more times a week 1 or more times a month

Are you at risk for AIDS (e.g., sexual orientation, drug abuse, previous blood transfusion)?
 No Yes, please explain _____

Deferred by patient: Signature _____

Patient Name _____

Today's Date: _____

Date of Birth: _____

REVIEW OF SYSTEMS

Do you currently have any problems with:

Eyes Circle One
 Blurred or double vision..... Yes No
 Glaucoma..... Yes No
 Any other..... Yes No

Ear, Nose, Mouth, & Throat Circle One
 Hearing loss or ringing..... Yes No
 Earaches or drainage..... Yes No
 Any other..... Yes No

Gastrointestinal
 Nausea or vomiting..... Yes No
 Change in bowel movements..... Yes No
 Any other..... Yes No

Genitourinary
 Frequent urination..... Yes No
 Burning or painful urination..... Yes No
 Any other..... Yes No

Psychiatric
 Memory loss or confusion..... Yes No
 Depression..... Yes No
 Any other..... Yes No

Endocrine
 Diabetes..... Yes No
 Glandular or hormone problem..... Yes No
 Any other..... Yes No

Cardiovascular
 Heart Trouble..... Yes No
 Chest pain or angina pectoris..... Yes No
 Hypertension..... Yes No
 Any other..... Yes No

Respiratory
 Shortness of breath..... Yes No
 Spitting up of blood..... Yes No
 Asthma or wheezing..... Yes No
 Any other..... Yes No

Constitutional
 Recent weight change..... Yes No
 Fever..... Yes No
 Headaches..... Yes No
 Any other..... Yes No

Musculoskeletal
 Joint pain..... Yes No
 Weakness of muscles or joints..... Yes No
 Neck or back pain..... Yes No
 Any other..... Yes No

Neurological
 Light headed or dizzy..... Yes No
 Convulsions or seizures..... Yes No
 Numbness or tingling..... Yes No
 Tremors..... Yes No
 Paralysis..... Yes No
 Stroke..... Yes No
 Head Injury..... Yes No
 Any other..... Yes No

The above information is accurate to the best of my knowledge

Patient Signature

Date

I have reviewed the above information with the patient

Physician printed name & signature

Date