

NEUROSCIENCE CONSULTANTS CARE CENTER I

PATIENT HEALTH HISTORY

1. ARE YOU ALLERGIC TO ANY MEDICATION? No Yes If yes, Please list below.

Name of medication

Type of Reaction

2. List any medication you are currently on: _____

3. NON- MEDICATION ALLERGIES

Are you allergic to any non-medications? Seafood Y/N Iodine Y/N Latex Y/N Other: _____

4. List any other Neurologist that you have seen in the past? _____

5. PAST HEALTH

Have you ever been diagnosed with any major health problem? Including but not limited to:

Cancer: No Yes (Type): _____ If yes, when _____

Heart and Blood Vessels:

Atrial fibrillation No Yes

Stroke No Yes

TIA No Yes

Congestive heart failure No Yes

Coronary artery disease No Yes

Elevated blood cholesterol No Yes

Heart attack No Yes

Heart disease No Yes

Heart valve defect No Yes

High Blood pressure No Yes

Irregular heart rate No Yes

Peripheral vascular disease No Yes

Kidney and Gender Problems:

Prostate enlargement No Yes If yes, when _____

Renal insufficiency No Yes if yes when _____

Mental & Emotional:

Alcohol or drug treatment No Yes

Anxiety, chronic No Yes

Depression No Yes

Other: _____

Glands, Hormones, and Sugar Control:

Diabetes (Type____) No Yes

Thyroid disease No Yes Type: _____

Lungs and Respiratory:

Asthma No Yes

COPD No Yes

Emphysema No

Blood & Lymph Node problems:

Hemophilia No Yes

Sickle cell anemia No Yes

Stomach and Digestive:

Stomach ulcer No Yes

Reflux No Yes

Hepatitis (type____) No Yes

Woman Only:

Are you Pregnant? No Yes Menstrual cycle age onset: _____

Menstrual period Normal? No Yes Number of Pregnancy : _____

Last menstrual period? _____ Number of Children: _____

4. SURGERIES AND HOSPITALIZATIONS

Have you been hospitalized for a medical problem before? Yes No

If yes, list hospitalizations, the reason for admission and the date. _____

5. FAMILY HISTORY: No family history of significant or pertinent health problems

Heart and Blood Vessels:

Heart Disease before age 60 Mother Father Brother Sister
High Blood Pressure Mother Father Brother Sister
Other: _____ Mother Father Brother Sister

Brain & Nervous:

Dementia Mother Father Brother Sister
Stroke Mother Father Brother Sister
Other: _____ Mother Father Brother Sister

Lungs and Respiratory:

Lung Cancer Mother Father Brother Sister
Asthma Mother Father Brother Sister
Other: _____ Mother Father Brother Sister

Glands, Hormones & Sugar

Diabetes Mother Father Brother Sister
Other: _____ Mother Father Bro/Sis

Skin &/or Breast

Breast Cancer Mother Father Brother Sister
Skin Cancer Mother Father Brother Sister
Other: _____ Mother Father Brother Sister

Blood & Lymph node problem:

Bleeding/clotting problem:
 Mother Father Brother Sister
Other: _____ Mother Father Bro/Sis

6. SOCIAL HISTORY

What is or was your occupation? _____ Check here if you are retired.

Have you ever used tobacco in any form? Yes No If yes, please complete the following:

<u>Type of Tobacco</u>	<u>From Year</u>	<u>To Year</u>
Cigarettes per day: _____	_____	_____
Other: (lit type) _____	_____	_____

Are you exposed to second hand smoke? Yes No

Have you ever used alcohol in any form? Yes No If yes, please complete the following:

<u>Type of alcohol</u>	<u>From Year</u>	<u>To Year</u>
Beers per week: _____	_____	_____
Wine glasses per week: _____	_____	_____
Other: (list type) _____	_____	_____

Do you have a living will? No Yes

Caffeine use: none about 1 cup/day 2-3 cups/day Other

In what languages do you comfortably communicate? English Spanish Other _____

Race: White Black/African American Spanish/Hispanic Asian Other : _____