

# NEUROSCIENCE CONSULTANTS CARE CENTER I

**Chief Complaint:** \_\_\_\_\_

## **PATIENT HEALTH HISTORY**

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

Name of medication

Type of Reaction

_____	_____
_____	_____

## 2. **NON-MEDICATION ALLERGIES**

Are you allergic to any non-medications? Seafood Yes / No Iodine Yes / No Latex Yes / No Other: \_\_\_\_\_

3. List any prescribe medication(s) you are currently on:

Name of Medication:

Dosage:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

## 5. **PAST MEDICAL HISTORY**

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

**Cancer:**  No  Yes (Type): \_\_\_\_\_

### **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 abnormality  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

Renal insufficiency  No  Yes

### **Mental & Emotional:**

Alcohol or drug treatment  No  Yes

Chronic Anxiety  No  Yes

Depression  No  Yes

Bipolar disorder  No  Yes

Other: \_\_\_\_\_

### **Glands, Hormones, and Sugar Control:**

Diabetes (Type \_\_\_\_\_)  No  Yes

Thyroid disease  No  Yes Type: \_\_\_\_\_

**Lungs and Respiratory:**Asthma  No  YesCOPD  No  YesEmphysema  No  Yes**Blood & Lymph Node problems:**Hemophilia  No  YesSickle cell anemia  No  YesBleeding disorder  No  Yes**Stomach and Digestive:**Stomach ulcer  No  YesReflux  No  YesHepatitis (type \_\_\_\_\_)  No  Yes**Woman Only:**Are you Pregnant?  No  Yes if yes: Trimester: \_\_\_1<sup>st</sup> \_\_\_2<sup>nd</sup> \_\_\_3<sup>rd</sup> Menstrual cycle age onset: \_\_\_\_\_Menstrual period Normal?  No  Yes Number of Pregnancy : \_\_\_\_\_

Last menstrual period? \_\_\_\_\_

**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  SisterHigh Blood Pressure  Mother  Father  Brother  SisterOther: \_\_\_\_\_  Mother  Father  Brother  Sister**Brain & Nervous:**Dementia  Mother  Father  Brother  SisterStroke  Mother  Father  Brother  SisterOther: \_\_\_\_\_  Mother  Father  Brother  Sister**Lungs and Respiratory:**Lung Cancer  Mother  Father  Brother  SisterAsthma  Mother  Father  Brother  SisterOther: \_\_\_\_\_  Mother  Father  Brother  Sister**Glands, Hormones & Sugar**Diabetes  Mother  Father  Brother  SisterOther: \_\_\_\_\_  Mother  Father  Bro/Sis**Skin &/or Breast:**Breast Cancer  Mother  Father  Brother  SisterSkin Cancer  Mother  Father  Brother  SisterOther: \_\_\_\_\_  Mother  Father  Brother  Sister**Blood & Lymph node problem:**

Bleeding/clotting problem:

 Mother  Father  Brother  SisterOther: \_\_\_\_\_  Mother  Father  Bro/Sis**6. SOCIAL HISTORY**Please check one:  Single  Married  Widowed  Divorced  Separated / Number of Children: \_\_\_\_\_Do you have a living will :  Yes  NoWhat is or was your occupation? \_\_\_\_\_  Check here if you are retired.Have you ever used tobacco in any form?  Yes  NoType of Tobacco From Year To Year

Cigarettes per day: \_\_\_\_\_

Other: (type) \_\_\_\_\_

Have you ever used alcohol in any form?  Yes  No If yes, please complete the following:Type of alcohol From Year To Year

Beers per week: \_\_\_\_\_

Wine glasses per week: \_\_\_\_\_

Other: (type) \_\_\_\_\_

Caffeine use:  none  about 1 cup/day  2-3 cups/day  OtherIn what languages do you comfortably communicate?  English  Spanish  Other \_\_\_\_\_Race:  White  Black/African American  Hispanic  Asian  Other: \_\_\_\_\_

## 7. REVIEW OF SYMPTOMS

**Constitutional:** \_\_\_ Fever  
\_\_\_ Unexplained weight change

**Eyes:** \_\_\_ Loss of vision  
\_\_\_ Double Vision

**ENT:** \_\_\_ Hearing loss  
\_\_\_ Tinnitus  
\_\_\_ Sore throat

**Cardiovascular:** \_\_\_ Chest pain  
\_\_\_ Palpitations

**Respiratory:** \_\_\_ Wheezing  
\_\_\_ Shortness of breath  
\_\_\_ Cough

**Gastrointestinal:** \_\_\_ Abdominal pain  
\_\_\_ Nausea  
\_\_\_ Vomiting  
\_\_\_ Change in bowel function

**Genitourinary:** \_\_\_ Polyuria  
\_\_\_ Incontinence

**Skin:** \_\_\_ Rashes  
\_\_\_ Birthmarks

**Psychiatric:** \_\_\_ Depression  
\_\_\_ Suicide attempts/plans  
\_\_\_ Anxiety disorders

**Endocrine:** \_\_\_ Excessive thirst  
\_\_\_ Temperature intolerance

**Hematological/Lymphatic:** \_\_\_ Abnormal bleeding  
\_\_\_ Excessive bruising  
\_\_\_ Swollen nodes