HOPE Neurology

NEUROLOGY CLINIC - HEALTH HISTORY QUESTIONAIRE

PATIENT INFORMATION			
Date	Name		
SSN	DOB	Age	□ Male □ Female
Marital Status □Single □Married □Separated □Divorced □Widow/Widower			
Current Job	Employer		
Previous Job	Employer		
Referring Physician			
Other Providers			

CHIEF COMPLAINT	
Reason for today's visit	

PERSONAL HEALTH HISTORY			
Childhood Illnesses	□ Measles □ Mono	□ Rubella □ Chicken Pox	□ Rheumatic Fever □ Polio

Condition/Disease – Past or Current	
□ Anemia	□ High Blood Pressure
□ Arthritis	□ HIV/AIDS
□ Asthma/Emphysema	□ Kidney Disease
□ Blood Disorders	□ Lung Disease
□ Cancer	□ Seizures/Epilespy
□ Diabetes	□ Stroke
□ Gallbladder Disease/Stones	□ Thyroid Disease
□ Glaucoma	□ Tuberculosis
□ Crohn's Disease/Colitis	□ Ulcers/Stomach Pain
□ Heart Disease	□ Thyroid Disease
□ Heart Attack	□ Tuberculosis
□ Hepatitis	□ Ulcers/Stomach Pain
Please explain any boxes that are checked	

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Surgery/Hospitalization	Reason	Age at Treatment

FAMILY HEALTH HISTORY			
	Age	Age at Death	Health Issue or Cause of Death
Mother			
Maternal Grandmother			
Paternal Grandmother			
Father			
Maternal Grandfather			
Paternal Grandfather			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			
Child			
Child			
Child			

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MEDICATIONS (Prescription, Over the Counter, Vitamins, Inhalers)							
	Medication	Qty / MG	Frequency		Medication	Qty / MG	Frequency
1				10			
2				11			
3				12			
4				13			
5				14			
6				15			
7				16			
8				17			
9				18			

Allergies to Medication	**Type of Reaction**

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Please check any symptom that you are currently experiencing:

GENERAL
□ Fever
□ Weight Loss
□ Night Sweats

ENDOCRINE
□ Thyroid Problem/Goiter
□ Diabetes

HEAD/EYES/EARS/NOSE/THROAT
□ Vision Issues
□ Dry Eyes
□ Hearing Issues
□ Ringing in Ears
□ Nosebleeds
□ Sinus Problems
□ Dry Mouth

GASTROINTESTINAL
□ Trouble Swallowing
□ Indigestion/Heartburn
□ Ulcers
□ Frequent Constipation
□ Frequent Diarrhea
□ Hepatitis/Liver Disease
□ Special Diet

PULMONARY
□ Shortness of Breath
□ Wheezing/Asthma/Emphysema
□ Tuberculosis / Positive TB Test

CARDIOVASCULAR
□ High Blood Pressure
□ Heart Disease
□ Heart Attack/Failure
□ Heart Value Issue
□ Heart Palpitation Rapid
□ Heart Palpitation Slow
□ High Cholesterol

NEUROLOGIC
□ Headaches
□ Seizures/Convulsions
□ Numbness/Loss of Sensation
□ Loss of Muscle Power
□ Tremors/Shaking
□ Concussion/Whiplash Injury
□ Trouble Sleeping
□ Snoring
□ Falling Asleep Driving
□ Trouble Walking
□ Trouble with Speech
□ Frequent Dizziness
□ Motion Sickness
□ Double Vision
□ Stroke

HEMATOLOGIC
□ Bruise/Bleed Easily
□ Anemia
□ Iron Deficiency
□ B12 Deficiency

RHEUMATOLGIC
□ Lupas/Sjogrens/Rheumatoid
□ Arthritis/Joint Pain/Swelling
□ Back/Neck Pain

DERMATOLOGIC
□ Skin Problems
□ Rash/Acne/Moles
□ Malignant Melanoma
□ Skin Cancer

PSYCHOLOGIC
□ Major Stress
□ Depression
□ Panic
□ Appetite/Eating Issues
□ Frequent Crying
□ Suicide Attempt
□ Thoughts of Hurting Yourself
□ Trouble Sleeping
□ Stress at Home
□ Stress at Work
□ Other Stress

WOMEN ONLY-GENITOURINARY
□ Number of Pregnancies _____
□ Number of Live Births _____
□ Pregnant
□ Breastfeeding
□ Hysterectomy
□ Bladder Problems
□ Kidney Disease

MEN ONLY-GENITOURINARY
□ Frequent Night Urination
□ Number of Times per Night ____
□ Bladder Problems
□ Erection/Ejaculation Issues
□ Kidney Disease

SOCIAL HISTORY
Do you use tobacco/chew?
□Yes □No □Past
Cigarettes/chew per day?____
Years of tobacco use?_____
Years since stopping?_____

Do you drink alcohol?
□Yes □No □Past
Drink more than 2 alcoholic beverages per day?
□Yes □No □____Qty

Coffee/Caffeine usage
□Yes □No □Past
Amount per day?_____

Recreational Drugs-Cocaine, Mariuana, methamphetamine?
□Yes □No □Past

Toxic Exposure?
□Yes □No □Past

VACCINATIONS
□Flu
Date: _____
□Pneumonia
Date: _____