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Patient History Questionnaire

Dear Patient:

Welcome to Neurology Associates of Monroe County. Please complete this questionnaire to the best of your knowledge. This questionnaire will allow the doctor to get to know more about you, your medical condition, your family and your habits. This questionnaire is confidential and the information contained in it will become a part of your medical record. Please fill this form out prior to your visit, and bring it with you on the date of your appointment so that there will be no delay when you arrive.

Patient Name: _____ Age _____
Last First Middle Initial

Sex M or F; Handedness Rt or Lf

Referring Physician: _____ Family Physician _____

Chief Complaint: _____ Date of Accident/Onset _____

PAST MEDICAL HISTORY

Diabetes	Peripheral Vascular disease	Cerebral Palsy
Hypertension	Thyroid Disease	Downs syndrome
High Cholesterol	Depression	Dementia
Anemia	Ulcers	Memory Loss
Heart Disease	Kidney disease	Migraines
Heart Arrhythmia	Liver disease	Multiple Sclerosis
Lung Disease	Hepatitis	Myasthenia Gravis
Asthma	HIV	Parkinson's
Cancer (type)	Head Injury	Pain Syndrome
Arthritis	ALS	Seizures/Epilepsy
Stroke	Sleep disorders	Other _____

SURGERIES

Year	Surgery	Year	Surgery
1.		5.	
2.		6.	
3.		7.	
4.		8.	

MEDICATION HISTORY:

Pharmacy that you use: _____ Location: _____

Current Medications	Strength/Dosage	Prescribed by:	Discontinued Medications

ALLERGIES

Please list any medications that you are allergic to.

Medication	Describe Allergic Reaction
1	
2	
3	
4	

Other Allergies (food or environment) _____

SOCIAL HISTORY

Marital Status: Single; Married; Divorced; Widowed

Occupation (Present) _____ Occupation (Past) _____

Do you smoke? Yes; No Do you use smokeless tobacco? Yes; No

History of Smoking: Quantity _____; # of Yrs _____ History of Alcohol: Quantity _____; # of Yrs. _____

Caffeine Intake? _____ Drugs? _____ At Risk for HIV: Yes or No

Education: Grade School; High School; College 2 or 4 years; Post Graduate

Living Environment: Private Home; Nursing Home; Home Care
Assisted Living/Group Home; Homeless; Other _____

Do you have a Living Will or Advanced Directive? Yes; No

FAMILY MEDICAL HISTORY - Do you have a father, mother, sibling or child with a history of any of the following?

- | | | |
|---------------------|---------------------|----------------------|
| High Blood Pressure | Parkinson’s Disease | Psychiatric Disease |
| Headaches | Tremor | Anemia/Blood disease |
| Diabetes | Seizures | Brain Tumors |
| High Cholesterol | Neuropathy | Genetic Conditions |
| Stroke | Muscle Disease | Other (Specify) |
| Cancer | Arthritis | |

Alzheimer’s Disease/Dementia Alcoholism/Drug Abuse

LIST ANY TESTS DONE FOR THE CURRENT PROBLEM

Date	Test	Facility Where Done