MEDICAL HISTORY **Appointment Date: _____**

NorthEast Neurology

Name: _____ Birth Date: _____

Age: _____ Medical Dr: _____ Referring Dr: _____

Are you employed full time: ☐Yes ☐No Employer: _____

Present illness (Why are you seeing the neurologist?)_____

_____

_____

When did the problem start? _____

List all surgeries and the dates they were performed: _____

_____

_____

In the past, have you ever been seen by a neurologist? ☐No ☐Yes

If so: When: _____ Name: _____ Location: _____

What illnesses have you had in the past and when? _____

_____

Head injury? no_____ yes_____ Describe_____

_____

_____

Transfusions? no_____ yes_____ Date_____

What medications are you currently taking, what dosages and how often are you taking them?

Medication?	Dose?	When do you take it?

Attach additional pages as needed

List your pharmacy names and locations: _____

_____

Are you allergic to any medications? no_____ yes_____

If yes, please list and describe your reaction: _____

_____

_____

(OVER)

Do you have any additional allergies (food, bee stings, latex, etc.)? no_____ yes_____

If yes, please list and describe: _____

_____

_____

What illnesses did you have as a child?

Mumps	no_____	yes_____	Mono	no_____	yes_____
Measles	no_____	yes_____	Chicken Pox	no_____	yes_____
Polio	no_____	yes_____	Hepatitis	no_____	yes_____
Scarlet Fever	no_____	yes_____	Meningitis	no_____	yes_____

Other_____

OB/GYN:

At what age did you begin having your menstrual cycle? _____ Date of your last cycle: _____

How many pregnancies have you had including any miscarriages/abortions and when? _____

_____

How many deliveries and when? _____

_____

Are you currently on any type of birth control? no_____ yes_____ What type? _____

SOCIAL HISTORY:

Single_____ Married_____ Separated_____ Divorced_____ Widowed_____

Children? no_____ yes_____ How many? _____

Male(s)/ages: _____ Female(s)/ages: _____

Do you use tobacco products? no____ yes____ Have you ever used tobacco products? no____ yes____

What kind? _____ How much per day? _____

Have you ever used any kind of mind altering drugs? no_____ yes_____ : Specify_____

Do you drink alcohol? no_____ yes_____ How often? _____

Family History: Has a blood relative ever had the following?

Heart Disease	no_____	yes_____	Hypertension	no_____	yes_____
Strokes	no_____	yes_____	Diabetes	no_____	yes_____
Cancer	no_____	yes_____			

Are there any other diseases / illnesses that your family has had? _____

_____

_____