Adult Neurology Center, P.C.

MEDICAL HISTORY

_____ _____ _____

Patient's Name (Please Print) Birthdate Today's Date

Are you right or left handed? ☐ Right ☐ Left

Reason for today's visit: _____

List any tests you have had performed related to your reason for today's visit (MRI, EEG, etc):

Name of the test(s)	Facility where the test was performed	Date the test was performed

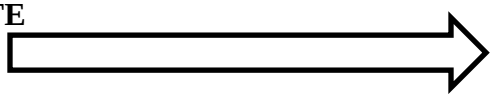
ALLERGIES (If yes, please list below. If none, please write NONE)

Medications	Dyes (used for MRI and other testing)	Other Substances

Current Medications (please include prescription and over-the-counter medications, and supplements

Name of Medication	Is this a Generic Drug	What is the dosage	How many time per day do you take this dose

FORM CONTINUES ON THE OTHER SIDE – PLEASE COMPLETE



Reason for last hospitalization:_____Date:_____Hospital:_____

Have you ever had any of the following medical conditions (Please *circle ALL that apply* & describe briefly below)

☐ 1-Diabetes	☐ 7-Hepatitis	☐ 14-Gained weight recently	☐ 21-Emotional problems
☐ 2-Stroke	☐ 8-Seizures	☐ 15-Lost weight recently	☐ 22-Nervousness
☐ 3-Cancer (list type below)	☐ 9-Convulsions	☐ 16-Heart disease	☐ 23-Anxiety
_____	☐ 10-Passing Out	☐ 17-High blood pressure	☐ 24-Depression
☐ 4-Lung Disease	☐ 11-Loss of consciousness	☐ 18-Kidney disease	☐ 25-Thyroid problems
☐ 5-Jaundice	☐ 12-Blood in urine	☐ 19-Stomach problems	☐ 26-Bladder changes
☐ 6-Liver Disease	☐ 13-Blood in bowel movemen	☐ 20-Serious head injury	☐ 27-Bowel changes

_____

_____

List previous surgeries:

_____

_____

Family History:

Please use the following symbols for family members' relationship to the patient:
F=father, **M**=mother, **S**=sister, **B**=brother, **MGM**= maternal grandmother, **MGF**= maternal grandfather, **PGM**=paternal grandmother, **PGF**=paternal grandfather, **A**=aunt, **U**=uncle

Relationship to the patient	**Diseases that could be inherited from the family member**
Example: F,M, B	*Diabetes*

Social History:

Do you?	**Yes**	**No**	**Never**	**Quit**	**How much? # per day**	**What type? (circle if applicable)**
Use Alcohol						☐ beer ☐ wine ☐ hard liquor
Use Tobacco						☐ cigarettes ☐ cigars ☐ pipe ☐ snuff ☐ leaf
Use Illicit Drugs						☐ marijuana ☐ cocaine ☐ barbiturate ☐ other
Consume Caffeine						☐ coffee ☐ tea ☐ chocolate ☐ soda
Have any risk for HIV						☐ tattoo ☐ piercing ☐ multiple partners
Are you employed?			**If employed, what is your occupation?**			
Are you retired?						

What is your marital status: ○ Single ○ Engaged ○ Married ○ Separated ○ Divorced ○ Widowed ○ Domestic Partnership