

HEALTH HISTORY

Name _____ Age _____ Date _____

Reason for visit _____

Primary Care Doctor: _____ Referring Doctor: _____

Current medications (*include dosage and schedule*):

- | | |
|-----------|------------|
| (1) _____ | (10) _____ |
| (2) _____ | (11) _____ |
| (3) _____ | (12) _____ |
| (4) _____ | (13) _____ |
| (5) _____ | (14) _____ |
| (6) _____ | (15) _____ |
| (7) _____ | (16) _____ |
| (8) _____ | (17) _____ |
| (9) _____ | (18) _____ |

ALLERGIES (*what type of reaction*): _____

PAST MEDICAL HISTORY

Describe the nature and year of past hospitalizations, surgeries and/or illnesses:

(OVER)

Please mark with X if any of the following apply:

- | | | |
|------------------------------------------------|---------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> memory decline | <input type="checkbox"/> double vision | <input type="checkbox"/> tics/twitching |
| <input type="checkbox"/> confusion | <input type="checkbox"/> blurred vision | <input type="checkbox"/> spasms/cramps |
| <input type="checkbox"/> word finding problems | <input type="checkbox"/> speech difficulty | <input type="checkbox"/> numbness |
| <input type="checkbox"/> fainting | <input type="checkbox"/> swallow difficulty | <input type="checkbox"/> tingling |
| <input type="checkbox"/> reading problems | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> headache |
| <input type="checkbox"/> sadness | <input type="checkbox"/> spells | <input type="checkbox"/> neck/back pain |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> weakness | <input type="checkbox"/> arm/leg pain |
| <input type="checkbox"/> insomnia | <input type="checkbox"/> falls | <input type="checkbox"/> bladder |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> dyscoordination | <input type="checkbox"/> bowels |
| <input type="checkbox"/> weight gain/loss | <input type="checkbox"/> gait problems | <input type="checkbox"/> breathing |
| <input type="checkbox"/> dizziness/vertigo | <input type="checkbox"/> balance | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> hearing loss | <input type="checkbox"/> shaking/tremors | <input type="checkbox"/> leg swelling |

Have you ever had:

- | | | |
|-------------------------------------------|--------------------------------------|----------------------------------------------|
| <input type="checkbox"/> stroke/TIA | <input type="checkbox"/> sleep apnea | <input type="checkbox"/> migraines |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> cancer | <input type="checkbox"/> birth control pills |
| <input type="checkbox"/> high cholesterol | <input type="checkbox"/> diabetes | <input type="checkbox"/> high blood pressure |

Occupation: _____ **Education level:** _____

Living arrangements: _____

Do you exercise? _____ **What type and how often?** _____

Do you drink alcohol? _____ **How much and how often?** _____

Do you smoke? _____ **How many packs per day?** _____

Have you ever used drugs? _____ **When and what type?** _____

Family History: *state relationship, age of occurrence, cause of death if applicable:*
