Methodist Neurology Associates - New Patient History

2800 E. Broad Street, Suites 421, 504, and 517, Mansfield, TX 76063
682-242-8930 Fax 817-453-8866

Name_____ **Date**_____

Who referred you to us?_____

Who is your primary care doctor?_____

What is your main problem for seeing the neurologist? _____

_____

Which doctors have evaluated or treated you for this problem? _____

_____

Which other doctors have treated you the past 5 years? _____

_____

_____

Circle the medical problems that you have or that you had in the past

Headache	Stroke	Transient ischemic attack
Brain aneurysm	Brain tumor	Seizures
Parkinson's disease	Dementia	Meningitis
Encephalitis	Polio	Guillain-Barre syndrome
Peripheral neuropathy	Head injury	Spinal fracture
Sleep apnea	Restless legs syndrome	Macular degeneration
Glaucoma	Amblyopia (lazy eye)	High blood pressure
High cholesterol	Heart attack	Atrial fibrillation
Congestive heart failure	Asthma	Emphysema
COPD	Tuberculosis	Pulmonary embolism
GE reflux	Peptic ulcer	Gallstones
Hepatitis	Kidney stones	Kidney failure or impairment
Erectile dysfunction	Menopause	Lupus
Sjogren's syndrome	Scoliosis	Depression
Anxiety	Phobias	Bipolar illness
Diabetes	Hypothyroid (low)	Hyperthyroid (overactive)
HIV or AIDS	Lung cancer	Colon cancer
Prostate cancer	Breast cancer	Vitamin B12 deficiency

Other significant illness (please list):

Name _____

Circle the operations that you have had

Appendectomy	Gallbladder	Gastric band
Gastric sleeve	Gastric bypass	Groin hernia
Carotid surgery: right left	Carotid stent: right left	Coronary bypass
Coronary angioplasty	Coronary stents	Pacemaker
Heart valve surgery	Brain: tumor aneurysm	Neck surgery (spine)
Low back surgery	Carpal tunnel: right left	Joint replacement
Knee surgery: right left	Hysterectomy	Ovary removed: right left
Tubal ligation	Endometrial (uterus) ablation	Kidney surgery: right left
Bladder surgery	LASIK	Cataract surgery: right left
Retinal: right left	Nasal Sinus	Uvulopalatopharyngoplasty
Melanoma	Cardiac defibrillator (ICD)	Tonsils & adenoids removed

Other operations_____

_____

_____

_____

Circle the medical problems of your blood relatives

Father	**Mother**	**Brother(s)**	**Sister(s)**
Dementia	Dementia	Dementia	Dementia
Diabetes	Diabetes	Diabetes	Diabetes
Headaches	Headaches	Headaches	Headaches
Heart attack	Heart attack	Heart attack	Heart attack
Multiple sclerosis	Multiple sclerosis	Multiple sclerosis	Multiple sclerosis
Muscular dystrophy	Muscular dystrophy	Muscular dystrophy	Muscular dystrophy
Narcolepsy	Narcolepsy	Narcolepsy	Narcolepsy
Parkinson's disease	Parkinson's disease	Parkinson's disease	Parkinson's disease
Peripheral neuropathy	Peripheral neuropathy	Peripheral neuropathy	Peripheral neuropathy
Restless legs	Restless legs	Restless legs	Restless legs
Seizures	Seizures	Seizures	Seizures
Sleep apnea	Sleep apnea	Sleep apnea	Sleep apnea
Stroke	Stroke	Stroke	Stroke
Tremor	Tremor	Tremor	Tremor

Other comments on your family medical history

Name _____

Do you smoke? Never Yes, daily Yes, not every day Used to smoke Year Quit_____

Do you drink alcoholic beverages? Yes Not now Never

Circle if you have: court appointed guardian

Marital status: single married divorced widowed separated

What is your work status? Please circle one.

Employed Unemployed On disability Homemaker Retired

Type of work:_____

What is your highest level of education?_____

Do you drive? Yes No I have been told not to drive

Are you right-handed left-handed ambidextrous (about the same)

Circle the symptoms that you <u>currently have</u>.

<u>General</u>
Excessive fatigue

<u>Eyes</u>
Vision problems

<u>Respiratory</u>
Shortness of breath

<u>Cardiovascular</u>
Palpitation or heart racing

<u>Gastrointestinal</u>
Constipation
Nausea

<u>Genitourinary</u>
Difficulty urinating
Urinary urgency or loss of control

<u>Musculoskeletal</u>
Arthralgia (joint pain)
Back pain
Myalgia (muscle pain)
Neck pain

<u>Allergy</u>
Allergy symptoms

<u>Neurological</u>
Dizziness
Headaches
Light-headed
Numbness
Recent seizure
Syncope (pass out)
Tremors
Weakness

<u>Hematologic</u>
Easy bruising

<u>Psychiatric and Cognitive</u>
Difficulty concentrating
Depression (dysphoric mood)
Hallucinations
Nervous or anxious
Sleep disturbance

Name _____

Write down drugs, tapes, or foods that you are allergic to or that you cannot tolerate and indicate the type of reaction that you have to it.

_____

_____

_____

_____

_____

Write down all medications, including non-prescription drugs and vitamins (<u>or provide a list</u>).

Name **Strength** **How many times per day**

_____

_____

_____

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