NEUROLOGY SPECIALISTS

History Form

Name SSN:

Medical Illnesses (please provide **year(s)** or **duration** of illness)

- □ Stroke(s) _____
- □ Brain hemorrhage _____
- □ Brain aneurysm _____
- □ Peripheral neuropathy _____
- □ Memory loss _____
- □ Dementia _____
- □ Parkinson's _____
- □ Seizures _____
- □ Headaches _____
- □ Migraines _____
- □ Carpal tunnel syndrome _____
- □ Heart attack (s) _____
- □ Heart failure _____
- □ Atrial fibrillation _____
- □ Pacemaker _____
- □ High blood pressure _____
- □ High Cholesterol _____
- □ Diabetes _____
- □ Liver disease _____
- □ Cancer *other:* _____
  - ↳□ prostate □ lung □ breast □ colon
- □ Hypo / Hyper-thyroidism _____
- □ Sleep apnea _____
  - ↳□ on CPAP / BiPAP
- □ Depression _____
- □ Bipolar disorder _____
- □ Drug abuse _____
- □ Anxiety disorder _____
- □ Asthma/COPD _____
- □ Lupus _____
- □ Kidney diseases _____
- □ Dialysis _____
- □ HIV/AIDS _____
- □ Other : _____

Surgeries (please provide **year(s)**)

- □ Abdominal surgery _____
- □ Neck surgery _____
- □ Back surgery _____
- □ Heart surgery _____
  - ↳□ bypass □ valve replaced / repaired
- □ Carotid artery: right / left _____
- □ Other vascular surgery _____
- □ Brain surgery _____
  - ↳□ aneurysm □ shunt □ bleeding
- □ Carpal tunnel: □ right □ left _____
- □ Other : _____

Family History (please circle **M**other / **F**ather / other relative)

- □ Tremor M / F / _____
- □ Parkinsons M / F / _____
- □ Dementia M / F / _____
- □ Migraines M / F / _____
- □ Seizures M / F / _____
- □ Stroke(s) M / F / _____
- □ Peripheral neuropathy M / F / _____
- □ Depression M / F / _____
- □ Mental illness M / F / _____
- □ Brain tumor M / F / _____
- □ Blood clots M / F / _____
- □ Diabetes M / F / _____
- □ High blood press. M / F / _____
- □ Heart disease M / F / _____
- □ Substance abuse M / F / _____
- □ Other inherited problem(s) : _____

Social History (only needed to determine impact on health/function)

education: □ *some* high school □ high school degree □ *some* college □ college degree □ post-graduate degree
tobacco: □ no □ yes, about _____ cigarette(s) / pack(s) per day for ____ years
alcohol: □ no □ yes, about _____ drink(s) per day / week / month
illicit drugs: □ never □ rarely □ frequently

Drug Allergies (reaction = rash, trouble breathing, palpitations, etc.)

drug: _____ *reaction:* _____
drug: _____ *reaction:* _____
drug: _____ *reaction:* _____
drug: _____ *reaction:* _____