



TEXAS NEUROLOGY CONSULTANTS, LLP

PATIENT HISTORY

Last Name	First	Middle	Date
Age	Sex	Right Handed / Left Handed?	Birthdate

Referring Physician (Name, Address, Phone, and Fax): _____

WHAT IS THE MAIN REASON YOU ARE SEEING A NEUROLOGIST? Describe onset, when did it start?, what makes worse or better?, etc)

MEDICAL HISTORY: list all medical conditions (e.g., diabetes, heart disease, high blood pressure, high cholesterol, arthritis, etc)

LIST ALL SURGERIES AND DATES: _____

Any major accidents or injuries: _____

Any recent hospitalizations? (If so give details)

Have you had any of the following problems? (If yes, explain)

Yes	No		Yes	No	
		Neurologic (seizure, stroke, etc)			Kidney or urinary problems
		Heart Disease			Sexual
		Lung Problems			Psychological
		Diabetes			Nervous breakdown
		High Blood Pressure			Ears, nose, or throat problems
		Abdominal, stomach/intestinal			Other: explain
		Cancer (explain where, when, and how treated)			

ALLERGIES TO MEDICATIONS: (List medication and reaction)

MEDICATIONS (List all medications with dosage and frequency you are currently taking? If needed attach separate page.)

Review of Systems: Do you have any of the following conditions or complaints at present?

	Yes	No	
Neurologic			Headache
			Fainting / Blacking out
			Seizures
			Dizziness
			Difficulty in Speech
			Memory problems more than age related peers
			Muscle weakness
			Numbness or tingling
			Difficulty walking
			Difficulty using hands
Constitutional			Tremors
			Fever
			Weight gain or loss
			Sleep problems
			Fatigue
Eyes			Double vision
			Blurred vision
			Eye pain
			Other
Ears, Nose, Throat			Difficulty swallowing
			Hearing loss
			Hearing aids?
			Ringing in ears
			Ear pain
Cardiac			Chest pain
			Palpitations
			Heart murmur
			Swelling in legs
Respiratory			Shortness of breath
			Cough
			Asthma
Gastrointestinal			Reflux / heart burn
			Nausea
			Vomiting
			Constipation
			Diarrhea
			Abdominal pain
Urologic			Bowel Incontinence
			Urinary Incontinence
			Urinary hesitancy / dribbling
			If male, prostate disorder
			Kidney stones
		Pain on urination	

	Yes	No	
Musculoskeletal			Muscle pain
			Joint pain (if yes, where?)
			Pain in any part of body (where?)
Psychiatric			Depression
			Anxiety
			Bipolar disorder
Endocrine			Diabetes
			Thyroid disorder
Hematologic			Anemia
			Easy bruising
Infectious			Sexually transmitted disease
For women only			Menstrual problems
			Are you pregnant?
			Are you planning on having children within the next year?
			Do you take birth control pills?
			Have you had a hysterectomy?
Other (Please list)			

SOCIAL HISTORY: Mark Y (yes) or N (No)

Do you smoke regularly? _____ How long? _____

Cigarettes ___ Pipe ___ Cigars ___ How many per day _____?

Do you drink alcohol? _____ Regularly? _____
 Beer ___ Wine ___ Hard liquor? _____ How much per day? _____
 How much per week? _____ How long? _____

Do you use any street drugs? _____

Are you or have you been addicted to any drugs or alcohol?

Any blood transfusions? _____ tattoos? _____
 Risky sexual activity for sexually transmitted diseases? _____

Are you single ___ married ___ divorced ___ or widowed? _____

What is your job? _____.

If retired, what did you do prior to retirement? _____

What is your highest level of education? _____

For Doctor's use only:

Reviewed by: _____ Date: _____

FAMILY HISTORY:

Any blood relative who has had the following? Mark yes or no and the relative who had (e.g. mother, father, paternal aunt or uncle, maternal grandfather, etc)?

- _____ Similar type of illness that you have now
- _____ Stroke
- _____ Alzheimer's or dementia
- _____ Migraines
- _____ Seizure disorder or epilepsy
- _____ Muscle disease
- _____ Nerve disease or neuropathy
- _____ Tremor
- _____ Parkinson's Disease

- _____ Heart Disease
- _____ High Blood Pressure
- _____ Diabetes
- _____ Cancer
- _____ Blood clotting disorder
- _____ Other

Are you adopted? Yes _____ No _____

Family History	If alive (good/fair/poor health) and illnesses	Age	Cause if deceased
Father			
Mother			
Brothers/Sisters (list individually)			
Children:			