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
			Tremors
Constitutional			**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
			Bowel Incontinence
Urologic			**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:			