NORTHOAKS NEUROLOGY
A Clinic of North Oaks Health System

PAST HISTORY, FAMILY HISTORY, SOCIAL HISTORY AND REVIEW OF SYSTEMS

TODAY'S DATE: ____/____/_____

Patient's Name: _____ Patient's Phone: (_____)_____ Cell Phone: (_____)_____

Referring Physician's Name: _____ Location: _____

Primary Care Provider: _____ Location: _____

Date of Birth: _____/_____/_____

Main Problem(s): (Please write brief description.)

_____

_____

_____

_____

_____

Social History: Age: _____ Height: _____ Weight: _____ kg's Handedness: ❑ Right ❑ Left

Marital Status: ❑ Married ❑ Single ❑ Widowed # of marriages_____ ❑ Divorced _____# of Divorces

Education Level: _____ Degree:_____ Occupation Current: _____ Previous: _____

Living Situation: ❑ Alone ❑ With Spouse ❑ With Friend ❑ With Child ❑ Parents ❑ Other: _____

❑ In-Home Care (if so, please describe.): _____

Who makes your medical decisions if you are incapable?_____ Power of Attorney: ❑ YES ❑ NO

Relationship_____

Tobacco: Current Use: ❑ YES ❑ NO Past Use: ❑ YES ❑ NO If quit, when? _____

If yes to either: Cigarettes: _____packs/day _____# years

Cigars: _____# years

Pipe: _____# years

Chewing tobacco: _____# years

Alcohol: Current use: ❑ YES ❑ NO Past Use ❑ YES ❑ NO If quit, when? _____

If yes, to either: Type: _____ Amount: _____ # drinks/day Problems with Alcohol ❑ YES ❑ NO

Drug Use: ❑ YES ❑ NO If yes, what? _____

Current Medications:

Medications	Strength	# pills/day	Medications	Strength	# pills/day
_____	_____ mg	_____	_____	_____ mg	_____
_____	_____ mg	_____	_____	_____ mg	_____
_____	_____ mg	_____	_____	_____ mg	_____
_____	_____ mg	_____	_____	_____ mg	_____
_____	_____ mg	_____	_____	_____ mg	_____

Medication Allergies: ❑ YES ❑ NO Medication(s): _____

Past Medical History:

Endocrine Disorders

Diabetes ❑ YES ❑ NO

Thyroid ❑ YES ❑ NO

Explain Other: _____

Cardiovascular Disorders

Blood Clots ❑ YES ❑ NO

High Blood Pressure ❑ YES ❑ NO

Atherosclerosis ❑ YES ❑ NO

Aneurysm ❑ YES ❑ NO

Vascular Surgery ❑ YES ❑ NO

Heart Attack ❑ YES ❑ NO

Heart Failure ❑ YES ❑ NO

Abnormal Rhythm ❑ YES ❑ NO

Fainting ❑ YES ❑ NO

Explain Other: _____

Lung Disorders

Asthma ❑ YES ❑ NO

COPD ❑ YES ❑ NO

Explain Other: _____

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Past Medical History (cont):

Kidney Disorders ❑ YES ❑ NO

Gastointestinal Disorders ❑ YES ❑ NO

Orthopedic (bone) Disorders ❑ YES ❑ NO

Neurologic Disorders

- Multiple Sclerosis ❑ YES ❑ NO
- Myasthenia Gravis ❑ YES ❑ NO
- Myopathy (muscle) ❑ YES ❑ NO
- Neuropathy (nerve) ❑ YES ❑ NO
- Parkinson's Disease ❑ YES ❑ NO
- Seizures ❑ YES ❑ NO
- Stroke ❑ YES ❑ NO
- Spine (disk) ❑ YES ❑ NO
- Neck (cervical) ❑ YES ❑ NO
- Low back (lumbar) ❑ YES ❑ NO
- **Explain other:** _____

Rheumatologic Disorders ❑ YES ❑ NO

- Rheumatoid Arthritis ❑ YES ❑ NO
- Gout ❑ YES ❑ NO
- Osteoarthritis ❑ YES ❑ NO
- (Degenerative arthritis)
- Chronic Fatigue Synd. ❑ YES ❑ NO
- Fibromyalgia ❑ YES ❑ NO

Explain Other: _____

Ophthalmologic Disorder ❑ YES ❑ NO

- Cataracts ❑ YES ❑ NO
- Retinopath ❑ YES ❑ NO
- Visual Loss ❑ YES ❑ NO
- Macular Degeneration ❑ YES ❑ NO

Explain Other: _____

Cancer ❑ YES ❑ NO

Explain Other: _____

Past Surgeries ❑ YES ❑ NO

- Back Surgery ❑ YES ❑ NO
- Coronary Artery Bypass ❑ YES ❑ NO
- Hip Surgery ❑ YES ❑ NO
- Knee Surgery ❑ YES ❑ NO
- Neck Surgery ❑ YES ❑ NO
- Prostate (TURP) ❑ YES ❑ NO
- Cancer ❑ YES ❑ NO

Explain Other: _____

Explain Other: _____

Accidents/Injuries ❑ YES ❑ NO _____

Dates of accidents: _____ Description: _____

Dates of accidents: _____ Description: _____

Were any accidents work-related? ❑ YES ❑ NO _____

Is any litigation (lawsuit) pending? ❑ YES ❑ NO _____

Family History: For living relatives, indicate age and any illnesses. For deceased relatives, indicate age at death and cause of death.

Living Relatives			**Deceased Relatives**	
Parents	Age	Illnesses	Age at Death	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____

Siblings: Brothers (B) & Sisters (S)

	Age	Illness	Age	Illness
B or S	_____	_____	_____	_____
B or S	_____	_____	_____	_____
B or S	_____	_____	_____	_____

Children: Sons (S) & Daughters (D)

S or D	_____	_____	_____	_____
S or D	_____	_____	_____	_____
S or D	_____	_____	_____	_____

List any disorders known to run in the family:

_____

_____

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Review of Systems
Current Symptoms

Constitutional

Weight Gain	❑ YES	❑ NO
Weight Loss	❑ YES	❑ NO
Fever	❑ YES	❑ NO
Chills	❑ YES	❑ NO
Night Sweats	❑ YES	❑ NO

Explain other: _____

Skin

Rashes	❑ YES	❑ NO
Other Skin Abn.	❑ YES	❑ NO

Explain other: _____

Eyes

Dry Eyes	❑ YES	❑ NO
Poor Vision	❑ YES	❑ NO
Both Eyes	❑ YES	❑ NO
Left Eye	❑ YES	❑ NO
Right Eye	❑ YES	❑ NO
Glasses	❑ YES	❑ NO
Contacts	❑ YES	❑ NO
Double Vision	❑ YES	❑ NO
Blurry Vision	❑ YES	❑ NO

Explain other: _____

Ears, Nose & Throat

Dry Mouth	❑ YES	❑ NO
Hearing Problem	❑ YES	❑ NO
Ringing in Ears	❑ YES	❑ NO
Vertigo (dizziness)	❑ YES	❑ NO
Swallowing Problems	❑ YES	❑ NO
Hoarseness	❑ YES	❑ NO

Explain other: _____

Lungs

Shortness of Breath	❑ YES	❑ NO
When Active	❑ YES	❑ NO
At Rest	❑ YES	❑ NO
Lying Flat	❑ YES	❑ NO
Cough	❑ YES	❑ NO
Wheezing	❑ YES	❑ NO

Explain other: _____

Heart

Chest Pain	❑ YES	❑ NO
Palpitation	❑ YES	❑ NO
Lightheadedness	❑ YES	❑ NO
Fainting Spells	❑ YES	❑ NO

Gastrointestinal

Loss of Appetite	❑ YES	❑ NO
Nausea	❑ YES	❑ NO
Vomiting	❑ YES	❑ NO
Diarrhea	❑ YES	❑ NO
Constipation	❑ YES	❑ NO
Bowel Incontinence	❑ YES	❑ NO
Blood in Stool	❑ YES	❑ NO

Explain other: _____

Genitourinary

Bladder Control	❑ YES	❑ NO
Frequent Urination	❑ YES	❑ NO
Burning with Urination	❑ YES	❑ NO
Pain with Urination	❑ YES	❑ NO
Difficulty Starting Urine	❑ YES	❑ NO
Blood in Urine	❑ YES	❑ NO
Sexual Problems	❑ YES	❑ NO

Explain other: _____

Blood

Easy Bleeding	❑ YES	❑ NO
Easy Bruising	❑ YES	❑ NO

Explain other: _____

Endocrine

Excessive Thirst	❑ YES	❑ NO
Feeling Hot	❑ YES	❑ NO
Menopause	❑ YES	❑ NO
PMS	❑ YES	❑ NO

Explain other: _____

Musculoskeletal

Muscle Pain	❑ YES	❑ NO
Joint Pain	❑ YES	❑ NO
Bone Pain	❑ YES	❑ NO
Muscle Swelling	❑ YES	❑ NO
Joint Swelling	❑ YES	❑ NO

Explain other: _____

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Neuromuscular (Check all that apply.)

Numbness	❑ face	❑ fingers	❑ hands	❑ arms	❑ toes	❑ feet	❑ legs	❑ abdomen	❑ back	❑ whole body
Tingling	❑ face	❑ fingers	❑ hands	❑ arms	❑ toes	❑ feet	❑ legs	❑ abdomen	❑ back	❑ whole body
Loss of feeling	❑ face	❑ fingers	❑ hands	❑ arms	❑ toes	❑ feet	❑ legs	❑ abdomen	❑ back	❑ whole body
Weakness	❑ face	❑ fingers	❑ hands	❑ arms	❑ toes	❑ feet	❑ legs	❑ abdomen	❑ back	❑ whole body

Difficulty Walking ❑ YES ❑ NO If yes, reason(s): ❑ pain ❑ fatigue ❑ poor balance ❑ weakness ❑ dizziness

Fatigue ❑ YES ❑ NO ❑ Difficulty Swallowig ❑ YES ❑ NO ❑ Difficulty Speaking ❑ YES ❑ NO

Psychiatric

Depression ❑ YES ❑ NO
Anxiety ❑ YES ❑ NO
Uncontrollable Thoughts ❑ YES ❑ NO
Past Suicidal Thoughts ❑ YES ❑ NO
Current Suicidal Thoughts ❑ YES ❑ NO

Explain other: _____

Sleep

Do you have trouble sleeping at night? ❑ YES ❑ NO
Do you snore at night? ❑ YES ❑ NO

Sleep (cont)

Are you sleepy during the day?
❑ YES ❑ NO
Do you have unwanted behaviors during sleep?
❑ YES ❑ NO
Do you or your partner notice you gasping for air during sleep?
❑ YES ❑ NO
Do you or your partner notice you holding your breath or stopping breathing during sleep?
❑ YES ❑ NO

EPWORTH SLEEPINESS SCALE: Use the following scale to choose the most appropriate number for each situation:
(**0=** no chance of dozing **1 =** slight chance of dozing **2 =** moderate chance of dozing **3 =** high chance of dozing)

Situation	Chance of Dozing
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in a public place (e.g. a theater or a meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car stopped for a few minutes in traffic	0 1 2 3
TOTAL	

Please provide the address of the physician that you would like this note to be sent to: (i.e., Primary Care Physician).

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Completed by: _____ Date: _____/_____/_____

Reviewed by: _____ Date: _____/_____/_____