THE NEUROLOGY CENTER MEDICAL HISTORY FORM

Service Date:	Attending Physician:
Patient Name:	Referring Physician:
Date of Birth:	Primary Care Physician:

CURRENT MEDICATIONS & DOSAGE REQUIREMENTS:

_____

PAST MEDICAL HISTORY (**Please circle all that is applicable.**)

Diabetes Heart Disease High Blood Pressure Migraine Seizures Stroke

Cancer (Type of Cancer) _____

Other neurological illnesses in other family members:_____

PAST SURGICAL HISTORY (**Please circle all that is applicable.**)

Brain Surgery Cervical Spine (Neck) Surgery Lumbar Spine (Low Back) Surgery

Pacemaker/ Defibrillator Pain Pump/ Spinal Cord Stimulator

Other surgeries: _____

FAMILY HISTORY (**Please circle all that is applicable.**)

Are you **Adopted**: Yes No

Father- Which of these medical conditions apply?

Alzheimer's Cancer Diabetes Heart Disease High Blood Pressure Migraine Multiple Sclerosis

Parkinson's Seizures Stroke Unknown

Is your **Father**: Alive Deceased Unknown

Mother- Which of these medical conditions apply?

Alzheimer's Cancer Diabetes Heart Disease High Blood Pressure Migraine Multiple Sclerosis

Parkinson's Seizures Stroke Unknown

Is your **Mother**: Alive Deceased Unknown

Children- Which of these medical conditions apply?

Alzheimer's Cancer Diabetes Heart Disease High Blood Pressure Migraine Multiple Sclerosis

Parkinson's Seizures Stroke Unknown

Do you have any **Children**? Yes No

Siblings- Which of these medical conditions apply?

Alzheimer's Cancer Diabetes Heart Disease High Blood Pressure Migraine Multiple Sclerosis

Parkinson's Seizures Stroke Unknown

Do you have any **Siblings**? Yes No

SOCIAL HISTORY (**Please circle all that is applicable.**)

Ethnicity: Caucasian Hispanic African-American Other _____

Preferred Language: English Spanish Russian Other _____

Smoking- Are you a:

Current some day smoker Current every day smoker Former smoker Uses tobacco in other forms Nonsmoker

Alcohol- Do you drink: Daily Occasionally Never

EMPLOYMENT

Job Title _____ Hours worked per day _____

Levels of Stress: _____ High _____ Medium _____ Low

Exposures: _____ Noise _____ Chemicals _____ Toxins _____ Fumes _____ Gases ____ Other: _____

ALLERGIES TO MEDICATIONS:

_____