Emerald Coast Center for Neurological Disorders

Patient Medical History

Patient Information

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____ Phone _____

Family Physician _____ Referring Physician _____

Medical History

Illnesses *(Have you ever been treated for any of the following? Please check all that apply.)*

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal rhythm	☐	☐	Drug addiction	☐	☐	Migraine
☐	☐	Alcoholism	☐	☐	Emphysema	☐	☐	Multiple sclerosis
☐	☐	Anemia	☐	☐	Epilepsy/seizure	☐	☐	Neuropathy
☐	☐	Anxiety	☐	☐	Fracture/broken bones (where)	☐	☐	Osteoporosis
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Parkinsonism
☐	☐	Asthma	☐	☐	Gout	☐	☐	Peptic ulcers
☐	☐	Blood clots	☐	☐	Heart disease	☐	☐	Prostate (cancer)
☐	☐	Blood transfusion	☐	☐	Hepatitis	☐	☐	Prostate (enlarged)
☐	☐	Brain hemmorhage	☐	☐	Hernia	☐	☐	Prostate (inflammation)
☐	☐	Brain tumor	☐	☐	High blood pressure	☐	☐	Psoriasis
☐	☐	Bronchitis	☐	☐	High cholesterol	☐	☐	Restless legs syndrome
☐	☐	Cancer (type)	☐	☐	HIV positive/AIDS	☐	☐	Sleep apnea
☐	☐	Cataracts	☐	☐	Kidney disease	☐	☐	Stroke
☐	☐	Colitis	☐	☐	Kidney stones	☐	☐	Thyroid disease
☐	☐	Congestive heart failure	☐	☐	Latex allergy	☐	☐	Other: _____
☐	☐	Depression	☐	☐	Leukemia	☐	☐	Other: _____
☐	☐	Diabetes	☐	☐	Liver cirrhosis	☐	☐	Other: _____
☐	☐	Diverticulitis	☐	☐	Meningitis	☐	☐	Other: _____

Surgeries *(Please check any surgeries which you have had.)*

Yes	No		Yes	No		Yes	No	
☐	☐	Appendectomy	☐	☐	D&C	☐	☐	Neck
☐	☐	Arthroscopy	☐	☐	Gallbladder	☐	☐	Pacemaker
☐	☐	Back	☐	☐	Heart bypass	☐	☐	Prostate
☐	☐	Breast	☐	☐	Heart valve	☐	☐	Skin cancer
☐	☐	Carpal tunnel	☐	☐	Hysterectomy	☐	☐	Tonsillectomy
☐	☐	Cataract	☐	☐	Joint replacement	☐	☐	Other: _____
☐	☐	Cesarean section	☐	☐	Kidney	☐	☐	Other: _____

Family History *(Please check any illnesses which have occurred in any of your blood relatives.)*

Yes	No			Yes	No		
☐	☐	Arthritis	*Relationship* _____	☐	☐	High blood pressure	*Relationship* _____
☐	☐	Brain tumor	*Relationship* _____	☐	☐	Stroke	*Relationship* _____
☐	☐	Diabetes	*Relationship* _____	☐	☐	Other: _____	*Relationship* _____
☐	☐	Heart attack	*Relationship* _____	☐	☐	Other: _____	*Relationship* _____
☐	☐	Heart disease	*Relationship* _____	☐	☐	Other: _____	*Relationship* _____
☐	☐	Migraine	*Relationship* _____	☐	☐	Other: _____	*Relationship* _____
☐	☐	Seizure	*Relationship* _____	☐	☐	Other: _____	*Relationship* _____

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Social History

Smoker? ☐ *Yes* ☐ *No* Packs per day? _____ Year quit? _____

Drink alcohol? ☐ *Yes* ☐ *No* # Drinks per day _____

Illicit drug use? ☐ *Yes* ☐ *No* What drug(s)? _____

Occupation _____

Medications *(Please list all prescription, over-the-counter, herbal supplements and vitamins.)*

MEDICATION NAME	*DOSAGE*

MEDICATION NAME	*DOSAGE*

Symptoms *(Please check any you are currently experiencing.)*

GENERAL

Yes	*No*	
☐	☐	Fever
☐	☐	Night sweats
☐	☐	Weight loss
☐	☐	Weight gain
☐	☐	Fatigue

CARDIOVASCULAR

Yes	*No*	
☐	☐	Chest pain
☐	☐	Irregular heartbeat
☐	☐	Passing out
☐	☐	Shortness of breath with mild exertion

EAR/NOSE/THROAT

Yes	*No*	
☐	☐	Vertigo
☐	☐	Lightheadedness
☐	☐	Neck pain
☐	☐	Loss of hearing
☐	☐	Ringing in the ears
☐	☐	Headaches

GASTROINTESTINAL

Yes	*No*	
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Constipation
☐	☐	Trouble swallowing

MUSCULOSKELETAL

Yes	*No*	
☐	☐	Joint pain
☐	☐	Joint swelling
☐	☐	Muscle pain
☐	☐	Muscle weakness

URINARY

Yes	*No*	
☐	☐	Urgency
☐	☐	Pain with urination
☐	☐	Incontinence
☐	☐	Incomplete emptying

PSYCHIATRIC

Yes	*No*	
☐	☐	Anxiety
☐	☐	Depression

EYES

Yes	*No*	
☐	☐	Double vision
☐	☐	Changes in vision
☐	☐	Sudden visual loss

RESPIRATORY

Yes	*No*	
☐	☐	Shortness of breath
☐	☐	Cough

ENDOCRINE

Yes	*No*	
☐	☐	Frequent urination
☐	☐	Increased thirst

HEME/LYMPH

Yes	*No*	
☐	☐	Easy bleeding
☐	☐	Easy bruising

SKIN

Yes	*No*	
☐	☐	Rash
☐	☐	Itching

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Drug Allergies *(Please list any medications to which you are allergic.)*

Sleep *(Please answer the following questions.)*

Do you snore?	☐ *Yes*	☐ *No*
Do you have trouble falling asleep?	☐ *Yes*	☐ *No*
Do you have trouble staying asleep?	☐ *Yes*	☐ *No*
When you awaken, do you generally feel that you had a good night's sleep?	☐ *Yes*	☐ *No*
In a relaxing situation, could you fall asleep without intending to?	☐ *Yes*	☐ *No*
Would you like these problems to be addressed, if applicable?	☐ *Yes*	☐ *No*

What question do you need to be answered today?