Metrolina Neurological Associates-Medical and Family History

Name:_____________________________Date of **Birth:**_________________________

Pharmacy: ____________________________________**Referring MD:** ___________________________

Chief Complaint:

____

History of Present Illness:

____

Height________ft.________in Weight________lbs.

Review of Systems: Please circle any of the following problems that you are currently having:

General:	Chills Fever Weight Gain Weight Loss
HEENT `	Diplopia Eye Pain Visual Disturbances Ear Problems Nose Problems Sinusitis Throat Problems Slurred Speech
Neck:	Neck Pain Neck Stiffness
Respiratory:	Difficulty Breathing Sputum Production
Cardiovascular:	Chest Pain Hypertension Shortness of breath
Gastrointestinal:	Abdominal Pain Difficulty Swallowing Nausea Vomiting
Musculoskeletal:	Back Pain Joint Pain Muscle Weakness
Neurological:	Black-Outs Bladder Symptoms Blurred Vision Bowel Symptoms Confusion
	Convulsions Difficulty with gait/walking Dizziness Double Vision Falling
	Headaches Hearing Loss Imbalance Memory Loss Muscle Cramping
	Muscle Twitching Numbness Pain Speech Disorder Syncope
	Tinnitus Vertigo Visual Loss Weakness
Psychiatric:	Anxiety Depression Disorientation Hallucinations Inability to Concentrate
Endocrine:	Appetite Changes Heat/Cold intolerance Thyroid Problems
Hematology:	Easy Bruising Easy Bleeding Painful Lymph nodes

Metrolina Neurological Associates-Medical and Family History

Name________________________________ Date_____________________________

Are you right or left handed? ❑ Right ❑ Left

MEDICAL HISTORY

- Epilepsy/Seizure________________________
- Cerebrovascular disease__________________
- Other Neuromuscular____________________
- Head injury____________________________
- Spinal Cord injury_______________________
- Cervical Spine disease____________________
- Lumbar Spine disease____________________
- Peripheral Nerve________________________
- CNS Malignancy________________________
- Depression_____________________________
- Coronary artery disease___________________
- Myocardial infarction_____________________
- Arrhythmias____________________________
- Congestive Heart Failure__________________
- Headache/Tension_______________________
- Headache/Migraine______________________
- Genitourinary Disease_____________________
- Venereal Disease__________________________
- Arthritis________________________________
- Cancer_________________________________
- Exposures_______________________________
- High Cholesterol__________________________
- Murmur_______________________
- Hypertension___________________
- COPD_________________________
- Pneumonia______________________
- Asthma________________________
- Peptic Ulcer Disease______________
- Colonic polyps___________________
- Bleeding disorder________________
- Anemia________________________
- Diabetes_______________________
- Peripheral Vascular Disease__________
- Thyroid Disease____________________
- Menstrual/sexual dysfunction_________
- Other Endocrine___________
- Liver Disease/Hepatitis______
- Renal Disease______________
- Mumps___________________
- Measles___________________
- Polio______________________
- Rheumatic Fever_____________
- Allergy/Hay Fever____________
- Other______________________
  ____

Allergies____

Current Medications:

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Metrolina Neurological Associates-Medical and Family History

Name__________________________Date___________________

Past Surgical: Please list any past surgeries that you have had and the approximate dates.

_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________

FAMILY HISTORY:

	Father	Mother	Father's Parents	Mother's Parents	Brother	Sister	Children
Heart Disease							
Hypertension							
Diabetes							
Cancer							
Arthritis							
Bleeding Disorder							
Kidney Disease							
Epilepsy/Seizures							
Stroke							
Mental Illness							
Dementia							
Thyroid Disease							
Headache							
Increased Lipids/High Cholesterol							
Neuromuscular/Nerve or muscle disease							

SOCIAL HISTORY:

Tobacco Use: ___Current every day Smoker ____Current Some Day Smoker ___Former Smoker-When did you quit? __
___Packs per day___Chewing tobacco____Snuff ____Never Smoked or used tobacco products

Alcohol Use: ___Occasional alcohol use ___Moderate alcohol use (2-3 drinks per day)
___ Heavy Alcohol Use (4 or more drinks per day) ___Past alcohol use ____Never used alcohol

Illicit Drug Use: ___No Illicit Drug Use___Occasional Drug use ___Moderate Drug Use
____Heavy Drug Use If you use any illicit drugs, list them and how often they are used:
____
____

Highest Level of Education: __Less than High School ___High School Graduate ___Some College
__College Graduate ___Post Graduate ____Other:________________

Work___None____Part-Time_____Full-Time____Student. If you work, list the type of work that you do:
____

Marital Status: __Single ___Married___Widowed____Divorced

Living Situation: ___Alone___With Spouse__With Parents___With Caregiver___Group Home___Other: _________

Where do you Live:____

Exposure to HIV: __Yes __No___Unknown