

Adult Neurology Center, P.C.

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MEDICAL HISTORY

Patient's Name (Please Print) _____
Birthdate _____
Today's Date

Are you right or left handed? Right Left

Reason for today's visit: _____

List any tests you have had performed related to your reason for today's visit (MRI, EEG, etc):

Name of the test(s)	Facility where the test was performed	Date the test was performed

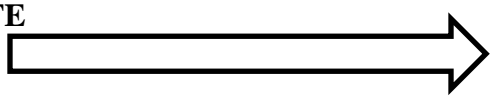
ALLERGIES (If yes, please list below. If none, please write NONE)

Medications	Dyes (used for MRI and other testing)	Other Substances

Current Medications (please include prescription and over-the-counter medications, and supplements)

Name of Medication	Is this a Generic Drug	What is the dosage	How many time per day do you take this dose

FORM CONTINUES ON THE OTHER SIDE – PLEASE COMPLETE



Reason for last hospitalization: _____ Date: _____ Hospital: _____

Have you ever had any of the following medical conditions (Please *circle ALL that apply* & describe briefly below)

1-Diabetes	7-Hepatitis	14-Gained weight recently	21-Emotional problems
2-Stroke	8-Seizures	15-Lost weight recently	22-Nervousness
3-Cancer (list type below)	9-Convulsions	16-Heart disease	23-Anxiety
_____	10-Passing Out	17-High blood pressure	24-Depression
4-Lung Disease	11-Loss of consciousness	18-Kidney disease	25-Thyroid problems
5-Jaundice	12-Blood in urine	19-Stomach problems	26-Bladder changes
6-Liver Disease	13-Blood in bowel movement	20-Serious head injury	27-Bowel changes

List previous surgeries:

Family History:

Please use the following symbols for family members' relationship to the patient:
F=father, **M**=mother, **S**=sister, **B**=brother, **MGM**= maternal grandmother, **MGF**= maternal grandfather,
PGM=paternal grandmother, **PGF**=paternal grandfather, **A**=aunt, **U**=uncle

Relationship to the patient	Diseases that could be inherited from the family member
<i>Example: F, M, B</i>	<i>Diabetes</i>

Social History:

Do you?	Yes	No	Never	Quit	How much? # per day	What type? (circle if applicable)
Use Alcohol						beer, wine, hard liquor
Use Tobacco						cigarettes, cigars, pipe, snuff, leaf
Use Illicit Drugs						marijuana, cocaine, barbiturate, other _____
Consume Caffeine						coffee, tea, chocolate, soda
Have any risk for HIV						tattoo, piercing, multiple partners
Are you employed?			If employed, what is your occupation?			
Are you retired?						
What is your marital status: Single Engaged Married Separated Divorced Widowed Domestic Partnership						