WESTERN NEUROLOGICAL ASSOCIATES

A MEDICAL CORPORATION

PATIENT'S HISTORY PART 1

You have an appointment to see Dr._____, a specialist in the practice of neurology on _____. Please complete the questions below carefully, (front and back).

DATE: _____ NAME:_____

AGE: _____ HEIGHT: _____

HANDEDNESS: R or L WEIGHT: _____

NAME OF PRIMARY CARE PHYSICIAN WHO SHOULD RECEIVE THE REPORT OF THIS CONSULTATION:_____.

COMPLAINT(S): List the main problem(s) for which you are seeking a neurological consultation (i.e. Headache, pain, weakness etc)

_____

_____

DESCRIBE YOUR MAIN PROBLEM IN DETAIL:

Date of onset (approximate): _____

Describe symptoms in detail: _____

_____

_____

_____

_____

Please check list of all **major medical problems/diseases** you have had (i.e. diabetes, hypertension, cancer, etc.)

- ☐ Hypertension
- ☐ Diabetes Mellitus
- ☐ Cancer. Where?
- ☐ Stroke
- ☐ Heart disease
- ☐ Headache
- ☐ Parkinson's disease
- ☐ Multiple Sclerosis
- ☐ Memory loss
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Sleep Disorder
- ☐ Depression/Anxiety
- ☐ Hand Pain/Numbness
- ☐ Other: _____
- ☐ _____

PLEASE FILL THE NEXT PAGE AS WELL!

PATIENT'S NEUROLOGY HISTORY PART 2

SOCIAL HISTORY:

CIRCLE ONE: Married Single Divorced Widowed Other

Where were you born?: _____

Occupation: _____ Alcohol intake:_____ How much_____ per day.

Smoking: _____ How much_____ per day. Recreational drugs: _____

Caffeinated Beverage intake: _____ How much_____ per day.

FAMILY HISTORY:

	CIRLCE ONE		RELATIONSHIP
Hypertension	Yes	No	_____
Diabetes	Yes	No	_____
Kidney Disease	Yes	No	_____
Tuberculosis	Yes	No	_____
Muscular Dystrophy	Yes	No	_____
Seizure Disorder	Yes	No	_____
Headache/Migraine	Yes	No	_____
Neurological Disorder	Yes	No	_____
Other	Yes	No	_____

LIST ALL MEDICATIONS: (Include birth control pills, any aspirin products, and over the counter medications)

NAME OF DRUG	DOSE	HOW OFTEN	DATE STARTED	PRESCRIBED BY
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

ALLERGIES (if any):_____