Patient Name: ______________________ Date: ______________________

Date of Birth: ______________ Referring Provider: ______________________

Please describe the problem you are seeing the doctor for: ______________________

____

System Review (Please Check)	Yes	No	Health History (Please Check)	Yes	No
1. Bowel/Bladder Problems			1. Anxiety		
2. Difficulty sleeping			2. Blackouts		
3. Dizziness			3. Blood Clots		
4. Do you use a CPAP?			4. Depression		
5. Falls/Gait disturbance			5. Diabetes		
6. Headache			6. Headache/Migraine		
7. Memory Changes			7. Heart Conditions		
8. Numbness/Tingling			8. High Blood Pressure		
9. Recent Weight Change			9. High Cholesterol		
10. Seizures			10. Mental Disorder		
11. Trouble Swallowing			11. Pacemaker		
12. Trouble Talking			12. Seizures		
13. Vision Disturbance			13. Stroke		
14. Weakness			14. Thyroid Disorder		

Family History (Please list relationship) Do any family members have a history of:	Yes	No	Relationship	**Surgery History** Please list Major Surgeries & approximate dates:
1. Cancer				
2. Carotid Disease				
3. Dementia				
4. Diabetes				
5. Heart Disease				
6. High Blood Pressure				
7. Migraine/Headache				
8. Parkinsons				
9. Peripheral Artery Disease				
10. Seizure				
11. Stroke				
12. Tremors				

Habits/Social History

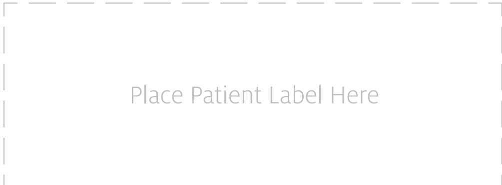
1. Have you ever smoke/chewed tobacco? ☐ ☐
   Packs/day _____ Years Smoked_____ Year Quit_____
2. Do you follow a special diet?
3. Do you use caffeine? ☐ ☐ Amount/day________
4. Do you use Alcohol? ☐ ☐ Amount/day________
5. Do you have a history of substance use/addiction? ☐ ☐
6. Occupation ______________________
7. Marital Status ______________________
8. Which dominant hand? ❑ Right ❑ Left

Have you had any of the procedure performed listed below? If so, when and where?

	Yes	No	Location
Carotid Doppler's			
CT Scan			
EEG			
EMG			
MRI Scan			

Bryan Physician Network

NEUROLOGY ASSOCIATES HEALTH HISTORY



Patient Name ______________________ **Date of Birth:** ______________________

Allergies

Please list any medications for which you have had an allergic reaction

Name of Medication	Describe Allergic Reaction

Medications

Name of Medication	Dose	How often Taken