

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Patient History Questionnaire  
NEUROLOGY Consultation

Dear

The purpose of this questionnaire is to obtain a detailed picture of your medical status. By completing these questions as fully and as accurately as you can, you will save both time and expense. You are kindly asked to answer these routine questions in your own time instead of using up your actual consulting time.

This information is strictly confidential.

If you have been hospitalized, or have been treated by another physician, it would be very helpful if you would contact all previous hospitals and physicians and send them a signed written request asking them to send a copy of your case history to me, before our consultation. This is very important. Doctors and hospitals are often slow to answer such requests. You should call the physician/institution in addition to sending them a request form.

Thank you.

Sincerely yours,

Maurice Preter, M.D.

\_\_\_\_\_

Today's Date: \_\_\_\_\_

1. General Information

Your Name: \_\_\_\_\_

Address: \_\_\_\_\_ ZIP \_\_\_\_\_

Telephone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Occupation: \_\_\_\_\_

Please Specify At Which Phone Number To Leave Messages: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Reason For Consultation: \_\_\_\_\_

\_\_\_\_\_

Referred By (e.g., doctor/other patient/self/website):

\_\_\_\_\_

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Your Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Your Place of Birth: \_\_\_\_\_

Do you live in a house, hotel, room, apartment, etc.? \_\_\_\_\_

With whom are you now living (List people): \_\_\_\_\_

Are you: Single – Married – Separated – Divorced – Widowed - Living with Significant Other

How would you describe your main problem or problems right now? \_\_\_\_\_

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What prior treatment did you receive for this problem/these problems?

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Please list ALL medications and their dosages (prescription and over-the-counter) you are currently taking: \_\_\_\_\_

List any surgeries you have had:

<i>Type of Operation</i>	<i>Year</i>	<i>Type of Operation</i>	<i>Year</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History: (Circle No or Yes)

Diabetes.....No	Yes	Kidney Disease.....No	Yes
High Blood Pressure.....No	Yes	Arthritis/Gout.....No	Yes
Cancer.....No	Yes	Thyroid Disease.....No	Yes
Stroke.....No	Yes	Bleeding Problems.....No	Yes
Heart Trouble.....No	Yes	Venereal Disease.....No	Yes
Lung Disease.....No	Yes	AIDS/HIV.....No	Yes
Liver Disease.....No	Yes	Hereditary Defects.....No	Yes

Social History: Do you smoke?.....No Yes If yes, current packs/day: \_\_\_\_\_  
 Do you drink alcohol?.....Never Rarely Moderate Daily

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Family Medical History	Alive	Age	Disease
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)/Sister(s)	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

**SYSTEM REVIEW**

**NOTES**

• **CONSTITUTIONAL SYMPTOMS**

Good general health lately	Yes	No
Recent Weight	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

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\_\_\_\_\_

\_\_\_\_\_

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• **EYES**

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

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\_\_\_\_\_

\_\_\_\_\_

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• **EARS/NOSE/MOUTH/THROAT**

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem, rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

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• **CARDIOVASCULAR**

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath	No	Yes
Swelling (feet, ankles, hands)	No	Yes

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• **RESPIRATORY**

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes
Do you snore ?	No	Yes

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\_\_\_\_\_

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

• GASTROINTESTINAL

Loss of appetite	No	Yes	_____
Change in bowel movements	No	Yes	_____
Nausea or vomiting	No	Yes	_____
Frequent diarrhea	No	Yes	_____
Painful bowel movements	No	Yes	_____
Constipation	No	Yes	_____
Rectal bleeding/blood in stool	No	Yes	_____
Abdominal pain or heart burn	No	Yes	_____
Peptic ulcer	No	Yes	_____

• GENITOURINARY

Frequent urination	No	Yes	_____
Burning or painful urination	No	Yes	_____
Blood in urine	No	Yes	_____
Change in force of strain	No	Yes	_____
Incontinence or dribbling	No	Yes	_____
Kidney stones	No	Yes	_____
Sexual difficulty	No	Yes	_____
Women-painful/irregular periods	No	Yes	_____
Women-vaginal discharge	No	Yes	_____
Women-date of last Pap smear			# Pregnancies _____ # Miscarriages _____

• MUSCULOSKELETAL

Joint Pain	No	Yes	_____
Joint stiffness or swelling	No	Yes	_____
Weakness of muscles or joints	No	Yes	_____
Back pain	No	Yes	_____
Cold extremities	No	Yes	_____
Difficulty in walking	No	Yes	_____

• INTEGUMENTARY (skin, breast)

Rash or itching	No	Yes	_____
Change in skin color	No	Yes	_____
Change in hair or nails	No	Yes	_____
Varicose veins	No	Yes	_____
Breast pain	No	Yes	_____
Breast lump	No	Yes	_____
Breast discharge	No	Yes	_____

• NEUROLOGICAL

Frequent or recent headaches	No	Yes	_____
Light-headed or dizzy	No	Yes	_____
Convulsions or seizures	No	Yes	_____
Numbness or tingling	No	Yes	_____
Tremors	No	Yes	_____
Paralysis	No	Yes	_____
Stroke	No	Yes	_____

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

- |                                       |    |     |       |
|---------------------------------------|----|-----|-------|
| Head injury                           | No | Yes | _____ |
| <b>• <u>PSYCHIATRIC</u></b>           |    |     |       |
| Memory loss or confusion              | No | Yes | _____ |
| Anxiety                               | No | Yes | _____ |
| Sadness                               | No | Yes | _____ |
| Insomnia/Trouble sleeping             | No | Yes | _____ |
| <b>• <u>ENDOCRINE</u></b>             |    |     |       |
| Gland or hormone problem              | No | Yes | _____ |
| Thyroid disease                       | No | Yes | _____ |
| Diabetes                              | No | Yes | _____ |
| Excessive thirst/urination            | No | Yes | _____ |
| Hot or cold tolerance                 | No | Yes | _____ |
| Skin or eyes becoming drier           | No | Yes | _____ |
| Change in hat or glove size           | No | Yes | _____ |
| <b>• <u>HEMATOLOGIC/LYMPHATIC</u></b> |    |     |       |
| Slow to heal after cuts               | No | Yes | _____ |
| Bleeding or bruising tendency         | No | Yes | _____ |
| Anemia                                | No | Yes | _____ |
| Phlebitis                             | No | Yes | _____ |
| Past transfusion                      | No | Yes | _____ |
| Enlarged glands                       | No | Yes | _____ |

**• ALLERGIC/IMMUNOLOGIC**

History of skin reaction or other unusual or adverse reaction to:

- |                                       |    |     |       |
|---------------------------------------|----|-----|-------|
| Penicillin or other antibiotic        | No | Yes | _____ |
| Morphine, Demerol,<br>other pain meds | No | Yes | _____ |
| Novocaine or other anesthetics        | No | Yes | _____ |
| Tetanus antitoxin or other serum      | No | Yes | _____ |
| Iodine, methylate or other            | No | Yes | _____ |

Adverse/Unexpected reaction to other drugs (e.g., corticosteroids? Non-steroidal anti-inflammatory drugs, e.g. Motrin?  
 No Yes \_\_\_\_\_

Are you sensitive to small doses of prescribed medication (e.g., pain killers, opiates, antidepressants, anti-anxiety drugs)?  
 No Yes \_\_\_\_\_

Known laundry detergent allergy No Yes \_\_\_\_\_

Known food allergies No Yes \_\_\_\_\_