EAST PORTLAND NEUROLOGY

MEDICAL HISTORY

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Name _____ Sex ☐ M ☐ F Age: _____ Date of Birth: _____

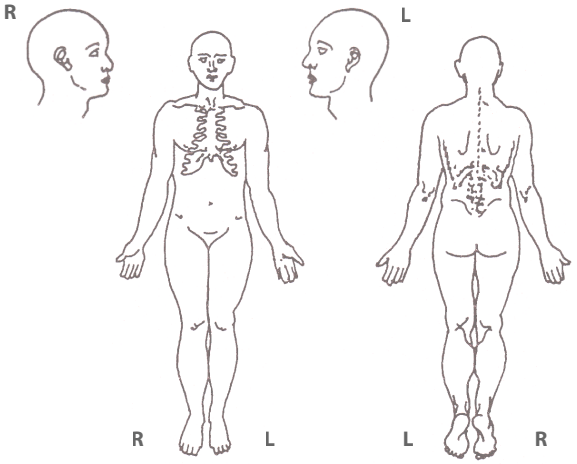
Height _____ Weight _____ Right-handed / Left-handed

Referring Physician or self: _____ PCP: _____ Appointment Date _____

HISTORY OF PRESENT ILLNESS AND CURRENT SYMPTOMS

MAIN Medical Symptom: _____

Please tell us IN DETAIL why you are here today: _____



Mark in the drawings to the right areas you have symptoms or discomfort --->

PAST MEDICAL HISTORY

Please mark any illnesses you have now or have had in the past:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Pacemaker
- ☐ Atrial fibrillation
- ☐ Stroke
- ☐ TIA
- ☐ Thyroid Disease
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Migraines
- ☐ Neck injury
- ☐ Back injury
- ☐ Cancer. Type? _____
- ☐ Depression
- ☐ Bi-polar
- ☐ Anxiety Disorder
- ☐ Other Mental Illness _____
- ☐ Restless Leg Syndrome
- ☐ Dementia
- ☐ Head injury
- ☐ Neuropathy
- ☐ Muscle disease
- ☐ Seizures
- ☐ Loss of Consciousness
- ☐ Brain tumor
- ☐ Ulcers
- ☐ GI Bleeding
- ☐ Liver disease
- ☐ Sleep Apnea ☐ On CPAP
- ☐ Kidney Disease
- ☐ Lung disease/Asthma
- ☐ Sexually transmitted disease
- ☐ Arthritis
- ☐ Other _____

SURGERIES

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please elaborate if necessary: _____

_____

PRESCRIPTION MEDICATIONS

Name	Dose (mg)	How often?

NON-PRESCRIPTION MEDICATIONS

_____
_____
_____

DRUG ALLERGIES

Name of drug	Type of reaction

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MEDICAL HISTORY (page 2 of 2)

Name _____

SOCIAL HISTORY

Are you: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Domestic Partner Do you have children? _____ Ages? _____

Living: ☐ With family ☐ With roommate(s) ☐ Alone ☐ Assisted Living ☐ Foster Home

Occupation (current or before retirement) _____ If on Disability: Cause _____

Do you smoke? ☐ Never ☐ Quit: What year? _____ ☐ Presently smoke: How much? _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit: Year _____ If yes, approximately how many drinks PER WEEK? ____ Wine ____ Beer ____ Hard liquor

Environmental Hazards or Poisons? _____ ☐ Previous or current use of illicit drugs _____

FAMILY HISTORY (OTHER THAN YOU)

Father's Age: _____ Deceased? _____ Mother's Age: _____ Deceased? _____

Please list which family members (including mother, father, grandmother, grandfather, brothers, sisters, children, aunts and uncles) have been afflicted next to each checked disorder:

☐ Diabetes _____
☐ High Blood Pressure _____
☐ Heart Disease _____
☐ Strokes, approx. age _____
☐ Cancer, Type _____

☐ Neuropathy _____
☐ Parkinson's Disease _____
☐ Tremors _____
☐ Seizures _____
☐ Migraines _____

☐ Alzheimer's Disease _____
☐ Brain Aneurysm _____
☐ Multiple Sclerosis _____
☐ Depression or other Mental Illness _____
☐ Carpal Tunnel Syndrome _____

REVIEW OF SYSTEMS

CHECK BOX IF NONE **CIRCLE AND EXPLAIN:**

Constitutional: ☐ Fevers, Sweats, Loss Of Appetite, Rapid Weight Loss Or Weight Gain, Fatigue, Insomnia, Daytime Sleepiness _____

Vision: ☐ Blurred, Double, Blindness _____

Ear, Nose, Throat: ☐ Headache, Loss Of Smell, Vertigo, Lightheadedness, Dizziness, Earache, Deafness, Ringing, Slurred Speech, Hoarse Voice, Poor Swallowing _____

Cardiovascular: ☐ Chest Pain, Palpitations, Murmur, Ankle Swelling _____

Respiratory: ☐ Shortness Of Breath, Asthma, Bronchitis, Cough, Loud Snoring _____

Gastrointestinal: ☐ Abdominal Pain, Diarrhea, Constipation, Bleeding, Nausea, Loss of Bowel Control, Vomiting, Jaundice, Hepatitis _____

Genito-urinary: ☐ Loss Of Bladder Control, Menstrual Irregularities, Prostate _____

Musculoskeletal: ☐ Joint Pain, Neck Pain, Back Pain, Arm (Pain / Tingling / Numbness), Leg (Pain / Tingling / Numbness) _____

Skin: ☐ Rash, Itching, Lumps, Discoloration _____

Neurological: ☐ Forgetfulness, Poor Concentration, Confusion, Disorientation _____
Seizures, Fainting, Slow Movements, Tremors _____
Poor Balance, Falls, Limping, Weak Arm, Weak Leg _____
Restless Legs At Night, Burning Pain In The Feet _____

Endocrine: ☐ Goiter, increased thirst _____

Hematologic: ☐ Bruising, Bleeding, Anemia _____

Allergy/Immune: ☐ Seasonal Allergies, Food Allergies _____

Psychiatric: ☐ Depression, Anxiety, Hallucinations, Personality Change, Lack Of Interest, Low Energy, Irritability, Aggressiveness, Agitation _____

Are you pregnant? Y N Do you use a birth control method? Y N *Please inform the doctor/nurse if you might become pregnant in the next year.*