Metrolina Neurological Associates- Medical and Family History

**Name:**_____________________________________________ **Date of Birth:**___________________________

**Pharmacy:** ________________________________________________**Referring Doctor:** _____________________________

**Chief Complaint:** ___________________________________________________________________________________

**History of Present Illness:** ________________________________________________________________________

______________________________________________________________________________________________________

**Review of Systems:** Please circle any of the following problems that you are currently having.

| | | | | | | |
|---|---|---|---|---|---|---|
| General: | Chills | Fever | Weight Gain | Weight Loss | | |
| HEENT: | Diplopia | Eye Pain | Visual Disturbances | Ear Problems | Nose Problems | Sinusitis |
| | Throat Problems | Slurred Speech | | | | |
| Neck: | Neck Pain | Neck Stiffness | | | | |
| Respiratory: | Difficulty Breathing | Sputum Production | | | | |
| Cardiovascular: | Chest Pain | Hypertension | Shortness of Breath | | | |
| Gastrointestinal: | Abdominal Pain | Difficulty Swallowing | Nausea | Vomiting | | |
| Musculoskeletal: | Back Pain | Joint Pain | Muscle Weakness | | | |
| Neurological: | Black-Outs | Bladder Symptoms | Blurred Vision | Bowel Symptoms | Confusion | |
| | Convulsions | Difficulty with gait/walking | Dizziness | Double Vision | Falling | |
| | Headaches | Hearing Loss | Imbalance | Memory Loss | Muscle Cramping | |
| | Muscle Twitching | Numbness | Pain | Speech Disorder | Syncope | Tingling |
| | Tinnitus | Vertigo | Visual Loss | Weakness | | |
| Psychiatric: | Anxiety | Depression | Disorientation | Hallucinations | Inability to Concentrate | |
| | Uncontrollable crying and/or laughing | | | | | |
| Endocrine: | Appetite Changes | Heat/Cold Intolerance | Thyroid Problems | | | |
| Hematology: | Easy Bruising | Easy Bleeding | Painful Lymph Nodes | | | |

**Are you right or left handed?** ❑ Right ❑ Right ❑ Left ❑ Left

**Past Medical History:** Please list any past major illnesses and major injuries that you have had and the approximate date.

Illnesses: _______________________________________________________________________________________

___________________________________________________________________________________________________



Patient Name ___________________________________ Date__________________________

Injuries:______________________________________________________________________________

**Allergies:** Please list any allergies that you have.

_______________________________________________________________________________________

**Family History:**

| | Father | Mother | Father's Parents | Mother's Parents | Brother | Sister | Children |
|---|---|---|---|---|---|---|---|
| Heart Disease ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ |
| Hypertension ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ |
| Diabetes ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ |
| Cancer ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ |
| Arthritis ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ |
| Bleeding Disorder ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ |
| Kidney Disease ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ |
| Epilepsy/Seizures ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ |
| Stroke ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ |
| Mental Illness ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ ❑ | ❑ |



Patient Name ___________________________________ Date__________________________

Dementia ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑

❑

Thyroid Disease ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑

❑

Headache ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑

❑

Increased Lipids/ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑

❑

High Cholesterol

Neuromuscular/ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑

❑

Nerve or Muscle Disease

**Social History:**

Tobacco Use: ❑ ❑ Current everyday smoker ❑ ❑ Current some day smoker ❑ ❑ Former Smoker - When did you quit? ________ ❑ ❑ Never Smoker ❑ ❑ Packs per day? ______ ❑ ❑ Chewing Tobacco ❑ ❑ Snuff

Alcohol Use: ❑ Occasional alcohol use ❑ Occasional alcohol use ❑ Moderate alcohol use (2 – 3 drinks per day) ❑ Moderate alcohol use (2 – 3 drinks per day)

- Never used alcohol ❑ Heavy Alcohol Use (4 + drinks per day)

❑ Heavy Alcohol Use (4 + drinks per day) ❑ Past Alcohol Use ❑ Past Alcohol Use

Illicit Drug Use: ❑No illicit drug use ❑No illicit drug use ❑ Occasional drug use ❑ Occasional drug use ❑Moderate Drug Use ❑Moderate Drug Use

❑ Heavy Drug use ❑ Heavy Drug use If you use any illicit drugs, list them and how often they are used: ______________________________________________________________________________

Highest Level of Education: ❑ Less than high school ❑ High school graduate ❑ Less than high school ❑ High school graduate

❑Some college ❑College gradute ❑Postgraduate

❑Some college ❑College gradute ❑Postgraduate ❑ Other: __________________ ❑ Other: __________________



Patient Name ____________________________________ Date__________________________

Work: ❑ None ❑ Part Time ❑ Full Time ❑Student ❑ None ❑ Part Time ❑ Full Time ❑Student If you work, list the type of work that you do: __________________

Marital Status: ❑Single ❑ Married ❑ Widowed ❑ Divorced ❑Single ❑ Married ❑ Widowed ❑ Divorced

Living Situation: ❑ Alone ❑ With Spouse ❑ With Parents ❑ With Caregiver ❑ Group Home ❑ Other: __________
❑ Alone ❑ With Spouse ❑ With Parents ❑ With Caregiver ❑ Group Home ❑ Other: __________

Where do you live? ______________________________________

Exposure to HIV: ❑ Yes ❑ No ❑ Yes ❑ No ❑ Unknown ❑ Unknown

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**Current Medications:** Please list all medications you are currently taking and the dosage.

_______________________________________________ _______________________________________________

_______________________________________________ _______________________________________________

_______________________________________________ _______________________________________________

_______________________________________________ _______________________________________________

_______________________________________________ _______________________________________________

_______________________________________________ _______________________________________________

**Past Surgical**: Please list any past surgeries that you have had and the approximate dates.

________________________________________________________________________________________

________________________________________________________________________________________

**Height: _______ ft _______in** **Weight: _______lbs**



Patient Name ______________________________________ Date___________________________