

Premier Neurology and Wellness Center  
 772-210-2447  
 772-261-4028

**MEDICAL HISTORY**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Present Problem: \_\_\_\_\_ Duration: \_\_\_\_\_  
 Prior treatment for current problem: \_\_\_\_\_

**Patient History:**

	YES	NO
Stroke/TIA	___	___
Diabetes	___	___
Head injury	___	___
Seizures	___	___
Headaches	___	___
Fainting	___	___
Parkinson's Disease	___	___
Tremor	___	___
Heart Disease	___	___
Atrial Fibrillation	___	___
Lung Disease	___	___

Bladder /Kidney disease	___	___
Bleeding disorder	___	___
Back problems	___	___
Neck problems	___	___
Blood thinners	___	___

<b>Family History:</b>	YES	NO	Relationship
Stroke	___	___	_____
Diabetes	___	___	_____
Seizure disorder	___	___	_____
Brain Aneurysm	___	___	_____
Heart disease	___	___	_____
Tremor	___	___	_____
Alzheimer's, Dementia or memory problems	___	___	_____
Dementia	___	___	_____
Brain tumor	___	___	_____
Muscle/Nerve disorder	___	___	_____
Parkinson's Disease	___	___	_____

**Allergies:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Previous Serious Illnesses or Hospitalizations:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Current Tobacco use:** YES \_\_\_ NO \_\_\_

**History of Tobacco use:** YES \_\_\_ NO \_\_\_

If yes to either of the above:

How many per day \_\_\_\_\_

How many years \_\_\_\_\_

When did you quit \_\_\_\_\_

**Alcohol use:** YES \_\_\_ NO \_\_\_

If yes, how many drinks per day? \_\_\_\_\_

Do you drink beer, wine, liquor? \_\_\_\_\_

**Drug use:** Y \_\_\_ N \_\_\_ Type \_\_\_\_\_ How often \_\_\_\_\_

**Caffeine intake:** Coffee Tea Soda Drinks per day \_\_\_\_\_

**Do you currently have:**

	YES	NO
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Headaches	___	___
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Recent changes in vision	___	___
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Nosebleeds	___	___
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Ringing in your ears	___	___
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Trouble speaking	___	___
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Difficulty swallowing	___	___
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Changes in your memory	___	___
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Depression	___	___
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Difficulty sleeping	___	___
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Snoring	___	___
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Daytime sleepiness	___	___
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Tremor	___	___
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Hallucinations	___	___
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Numbness or Tingling	___	___
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Weakness of arms or legs	___	___
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Recent weight loss	___	# of lbs?: ___
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Recent weight gain	___	# of lbs?: ___
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Trouble walking	___	___
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Balance problems	___	___
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Back problems	___	___
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Palpitations	___	___
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Chest pain	___	___
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Shortness of breath	___	___
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Urinary incontinence	___	___
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Abdominal pain	___	___
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Constipation	___	___
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Nausea/Vomiting	___	___
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Blood in stools	___	___
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**Previous Surgeries:**

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Bowel Incontinence

\_\_\_ \_\_\_

Leg swelling

\_\_\_ \_\_\_

Easy bruising

\_\_\_ \_\_\_

**Please circle: Right handed**

**Left handed**