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 | \_\_\_ | \_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **Family History:** | **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** |
| Headaches | \_\_\_ | \_\_\_ |
| Recent changes in vision | \_\_\_ | \_\_\_ |
| Nosebleeds | \_\_\_ | \_\_\_ |
| Ringing in your ears | \_\_\_ | \_\_\_ |
| Trouble speaking | \_\_\_ | \_\_\_ |
| Difficulty swallowing | \_\_\_ | \_\_\_ |
| Changes in your memory | \_\_\_ | \_\_\_ |
| Depression | \_\_\_ | \_\_\_ |
| Difficulty sleeping | \_\_\_ | \_\_\_ |
| Snoring | \_\_\_ | \_\_\_ |
| Daytime sleepiness | \_\_\_ | \_\_\_ |
| Tremor | \_\_\_ | \_\_\_ |
| Hallucinations | \_\_\_ | \_\_\_ |
| Numbness or Tingling | \_\_\_ | \_\_\_ |
| Weakness of arms or legs | \_\_\_ | \_\_\_ |
| Recent weight loss | \_\_\_ | \_\_\_ # of lbs?:\_\_\_ |
| Recent weight gain | \_\_\_ | \_\_\_ # of lbs?:\_\_\_ |
| Trouble walking | \_\_\_ | \_\_\_ |
| Balance problems | \_\_\_ | \_\_\_ |
| Back problems | \_\_\_ | \_\_\_ |
| Palpitations | \_\_\_ | \_\_\_ |
| Chest pain | \_\_\_ | \_\_\_ |
| Shortness of breath | \_\_\_ | \_\_\_ |
| Urinary incontinence | \_\_\_ | \_\_\_ |
| Abdominal pain | \_\_\_ | \_\_\_ |
| Constipation | \_\_\_ | \_\_\_ |
| Nausea/Vomiting | \_\_\_ | \_\_\_ |
| Blood in stools | \_\_\_ | \_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **Previous Surgeries:** | Bowel Incontinence | \_\_\_ | \_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Leg swelling | \_\_\_ | \_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Easy bruising | \_\_\_ | \_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Please circle: Right handed** |  | **Left handed** |