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