Please complete this form and bring with you to your appointment

DEPARTMENT OF NEUROLOGY - MEDICAL FACULTY ASSOCIATES

CLINICAL HISTORY FORM

Name: _____ Date: _____
LAST FIRST MI

Date of Birth: _____ Age: _____ Please circle: MALE FEMALE

Referring Doctor of Primary Care Physician: _____

Referring Doctor's Address: _____

What is the reason for your visit today? _____

Where is the location of the problem? _____When do symptoms occur? _____

What makes it worse? _____

What makes it better? _____

How long have you had these symptoms? _____Are the symptoms related to an injury? NO YES

Was the injury work related? NO YES, Date of injury: _____ Job Title or duties: _____

Are you presently working? NO YES Date last worked: _____ Work Capacity: FULL ___ PART____

Review of Systems: (Please check all that apply)

Constitutional
- ❑ Fever
- ❑ Night sweats
- ❑ Weight loss

Cardiovascular
- ❑ Shortness of breath
- ❑ Chest pain
- ❑ Irregular heartbeat

Respiratory
- ❑ Chronic cough/coughing blood
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Asthma

Gastrointestinal
- ❑ Blood in Stool/Dark stool
- ❑ Nausea/Vomiting
- ❑ Abdominal pain

Psychological
- ❑ Depression
- ❑ Anxiety

Genitourinary
- ❑ Burning with urination
- ❑ Difficulty starting/ending urine stream
- ❑ Poor bladder control of incontinence
- ❑ Sexual dysfunction
- ❑ Loss of sensation of genitals
- ❑ Inability to obtain, maintain erection

Endocrine
- ❑ Nipple discharge
- ❑ Dry skin
- ❑ Loss or gain of body hair
- ❑ Weight loss or weight gain
- ❑ Excessive thirst

Hematology
- ❑ Easy bruising
- ❑ Nose bleeds
- ❑ Excessive bleeding with previous surgeries

Neurological
- ❑ Change of vision (blurry, double)
- ❑ Loss of hearing of ringing in ears
- ❑ Facial numbness
- ❑ Facial weakness
- ❑ Decrease sense of smell or taste
- ❑ Difficulty swallowing
- ❑ Slurred speech
- ❑ Headache
- ❑ Dizziness
- ❑ Seizures
- ❑ Pain in the arm _____
- ❑ Pain in the leg _____
- ❑ Numbness of the arm
- ❑ Numbness of the leg
- ❑ Weakness in the leg

Musculoskeletal
- ❑ Neck pain
- ❑ Loss of arm/leg coordination
- ❑ Back pain
- ❑ Trouble walking

Past Medical History

❑ Heart Attack	❑ Diabetes	❑ Cancer
❑ Hear Disease	❑ Kidney problems	❑ HIV
❑ High blood pressure	❑ Liver disease	❑ Asthma of lung disease
❑ Other		

Past History of Surgery or Hospitalization

Date	Type of surgery of illness	Reason for Surgery or Hospitalization

Other information:

LABEL

Family History: Please list any medical problems that run in your family.

Father – age:_____ (alive/deceased):_____

Mother – age:_____ (alive/deceased):_____

Siblings – age:_____ (alive/deceased):_____

Siblings – age:_____ (alive/deceased):_____

Siblings – age:_____ (alive/deceased):_____

Social History:

Marital status: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWER

Education: ☐ GRADE SCHOOL ☐ MIDDLE SCHOOL ☐ HIGH SCHOOL ☐ GED ☐ COLLEGE

Do you exercise? NO YES How often per week?_____

Do you currently smoke? NO YES How much per day and for how many years?_____

Do you drink alcohol? NO YES Number of drinks per week? _____

Do you use illicit drugs? NO YES How much dollar amount used on drugs per week? _____

Are you on any special diet?_____

Allergies to Medication: List drug names and reaction to each drug.

_____

_____

_____

List Current Medications (attach a list if necessary)

Name of Medication	Dosage (milligrams)	Number of tablets taken in one day

PHARMACY – Name, Address, Contact Information:

_____

_____

_____

My signature signifies that I have read, answered, and truthfully understand the information included in this form as part of my medical evaluation.

_____

Patient Signature **Date**

LABEL

_____

Reviewed by MD **Date**