NEUROCARE CENTER

CONFIDENTIAL HEALTH HISTORY

Welcome. In order to provide you the very best care, we ask that you take a few minutes to complete this medical questionnaire. Thank you.

Name: _____ **Gender:** M____/F_____ **Date of Birth:** _____

Height: _____ **Weight:** _____

1. Current symptoms (for this visit) with: ____ **Dr. Babkes** ____ **Dr. Reaven**

Symptom (reason for visit)	Location (part of body)	Onset (when it started)	Severity (from 1-10)

2. Medication list (*current*)

Name	Dose (strength-in mgs.)	Frequency (how many per day)	Start date

3. Allergies: __ No known allergies **OR:**

_ Aspirin _ Penicillin _ Sulfa drugs _ x-ray dye _ Other (please list):_____

4. Review of Systems (please check off all that apply ***currently***):

Neurological	__ weakness/paralysis __ numbness __ difficulty speaking __ gait / balance difficulty
	__ headaches __ seizures __ involuntary movements / tremor __ forgetfulness
	__ fainting __ sleep problems __ other:
Immunologic	__ recent asthma attack __ allergies
Cardiovascular	__ chest pain __ leg pain __ elevated blood pressure __ heart murmur
	__ irregular heartbeat/palpitations __ shortness of breath
General	__ chills __ fever __ weight change __ night sweats
ENT	__ difficulty swallowing __ hearing loss __ ringing in ears
Endocrine	__ cold or heat intolerance __ excessive thirst __ hair loss
Eyes	__ abrupt visual loss __ blurred vision __ double vision __ eye pain __ visual spots
G.I.	__ abdominal pain __ constipation __ diarrhea __ appetite change
G.U.	__ changes in libido __ impotence __ urinary frequency __ incontinence __ retention
Skin	__ rashes __ dryness
Musc.Skeletal	__ neck/back pain __ joint pain __ joint swelling __ muscle cramps __ muscle pain
Psychiatric	__ depression __ panic attacks __ anxiety __ disorientation __ suicidal thoughts
Respiratory	__ shortness of breath __ cough __ snoring __ daytime drowsiness

5. **Past Medical History** (please check all that apply):

Neurological: __ brain aneurysm __ brain tumor __ dementia __ headaches __ head injury
__ memory problems __ muscle disorders __ multiple sclerosis __ neuropathy
__ stroke / TIA __ Parkinson's __ seizure disorder
Cardiovascular: __ heart disease __ high blood pressure __ murmur __ irregular heartbeat
Childhood illnesses: __ polio __ rheumatic fever __ meningitis __ asthma __ other:
Dermatologic (skin): __ rashes __ herpes zoster (shingles) __ melanoma __ other:
Endocrine / Hormonal: __ thyroid disorder __ diabetes __ other:
Gastrointestinal: __ liver problems __ bowel problems __ cancer __ inflammatory disease
__ ulcers __ other:
Renal (kidney)**/Urinary:** __ incontinence __ bladder dysfunction __ kidney stones __ other:
Eye /Ear/Nose/Throat: __ hearing loss __ Menieres __ infections __ glaucoma

Hematologic (blood): __ anemia __ cancer __ clotting problems __ other:
Inflammatory: __ sarcoidosis __ lupus __ polymyalgia __ other:
Infections: __ HIV / AIDS __ tuberculosis __ other:
Musculo-skeletal: __ arthritis __ spine disease __ bone cancer __ injuries __ other:
Other: _____

6. Past Surgical History: (please check all that apply)

___ Spinal surgery	___ Cancer surgery
___ CABG (coronary artery bypass)	___ Brain surgery
___ Carotid endarterectomy	___ Transplant
___ Pacemaker	___ Other:

7. **Family History:** (please check all that apply)

___ Abnormal movements (such as tremors)	___ Parkinson's disease
___ Migraines / headaches	___ Multiple Sclerosis
___ Hereditary muscle / nerve disease	___ Seizure Disorder
___ Dementia	___ Other:

8. Social History: (please check all that apply)

___ Tobacco use	___ Caffeine use	___ Alcohol use
___ Illegal drug use	___ Prescription drug abuse	___ Sexually transmitted disease
___ Non-use of seatbelts	___ Non-use of helmet	___ Lack of employment

Patient Name: (please print) _____

Patient Signature: _____

Today's Date: _____