NEUROCARE
CENTER

CONFIDENTIAL HEALTH HISTORY

Name:_____**Sex: M**___**/F**___**Date of birth:**_____

Height:_____**Weight:** _____ **Dr.:** ____ **Babkes /** ____ **Romanow /** ____ **Reaven**

Reason for visit: _____

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

Allergies:____No known drug allergies **OR:**____aspirin____Penicillin____Sulfa____contrast dye

___Other (please list):_____

Past Medical History: (please check all that apply and list others)

	Neurological			**Endocrine**			**Renal/G.U.**			**Infections**	
	brain aneurysm			thyroid disorder			incontinence			HIV/AIDS	
	brain tumor			diabetes			bladder dysfunction			tuberculosis	
	dementia			**Childhood Illness**			kidney stones			HSV	
	headaches			polio			**ENT**			**Musculoskeletal**	
	head injury			rheumatic fever			hearing loss			arthritis	
	memory problems			meningitis			Meniere's			spine disease	
	muscle disorders			**Dermatologic**			infections			bone cancer	
	multiple sclerosis			rash			glaucoma			injuries	
	neuropathy			shingles			vertigo			**Psychiatric**	
	stroke/TIA			melanoma			**Hematologic**			depression	
	Parkinson's			**Gastrointestinal**			anemia			bipolar disorder	
	seizure disorder			liver problems			cancer			anxiety	
	Cardiovascular			bowel problems			clotting problems			panic attacks	
	heart disease			cancer			**Inflammatory**			**Other**	
	high blood pressure			IBD			sarcoidosis				
	heart murmur			IBS			lupus				
	irregular heartbeat			ulcers			polymyalgia				

Past surgical history: (please check all that apply and list others)

	Spinal surgery			Cancer surgery			Carotid endarterectomy			Transplant	
	CABG			Brain surgery			Pacemaker			Other	

Social history: (please check all that apply)

	Tobacco use			Alcohol use			Caffeine use			Illegal drug use	

Family history: (please check all that apply and list others for parents, siblings, children):

	Abnormal movements			Hereditary muscle/nerve disease			Parkinson's disease			Seizure disorder	
	Migraine/headaches			Dementia			Multiple sclerosis			Other	

Review of Systems: (please circle all **current** symptoms)

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

Medication list: (include vitamins and supplements, attach list with additional medications)

Name	**Dose (mg)**	**Frequency (times per day)**		**Name**	**Dose (mg)**	**Frequency (times per day)**

Patient Signature:_____ **Date:**_____