St.JosephHealth Medical Group

Neurology

Name:_____ **Date of Birth**:_____

Date:_____**What is your preferred pharmacy**?_____

Primary Care Physician:-_____

What is the reason you are being seen today?_____

Have you ever seen a Neurologist before? Yes ☐ No ☐ If yes, why:_____

Please complete the following information regarding your past medical history:

Blood Disorder	Yes ☐ No ☐	Heart Condition	Yes ☐ No ☐	Meningitis	Yes ☐ No ☐
Blurred Vision	Yes ☐ No ☐	Headaches	Yes ☐ No ☐	Mental Illness	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐	Seizure(s)	Yes ☐ No ☐
Hearing Loss	Yes ☐ No ☐	Lapse of Consciousness	Yes ☐ No ☐	Stroke	Yes ☐ No ☐

Please list any surgeries you have had	Date		Date

List any immediate family members that have had any of the following diseases:

Disease	**Mother**	**Father**	**Brother**	**Sister**	**Son**	**Daughter**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**
Alcohol Problems										
Bleeding Tendency										
Cancer										
Convulsions										
Diabetes										
Drug Problems										
Heart Trouble										
High Blood Pressure										
Mental Illness										
Suicide/Severe Depression										

Personal History

Smoking Status: ☐ Never a smoker ☐ Former Smoker (if yes, year quit_____) ☐ Socially ☐ Smoker (*if yes ppd* _____)

Caffeine: ☐ Coffee ☐ Tea ☐ Soda ☐ Chocolate ☐ None

Do you drink alcohol: ☐ Yes ☐ No *(if yes how many*_____*)*

Do you use any street drugs: ☐ Yes ☐ No *(if yes, please list*_____*)*

Please Circle: Right-Handed Left Handed

Are you allergic to any medications? Yes ☐ No ☐ If yes, please list:_____

Medication (including OTC's)	**Dosage**	**Medication**	**Dosage**