High Country Neurology
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To help us take the very best care of you, we'd appreciate it if you would take the time to fill out the following brief medical history form, and bring it with you to your first appointment. Your doctor will review it in detail with you then. This is primarily to get an adequate history of your background medical problems, not necessarily the main problem you are seeing a neurologist for. Simply check the items that apply to you, and feel free to elaborate where needed. This document is just for information collection and pertinent information will be entered by our staff into your electronic chart. Thank you!

Please check the box if you have a history of or are being treated for any of the medical problems listed below:

GENERAL

___ fever, chills ___ weight gain, loss ___ trouble sleeping
___ fatigue ___ Snoring ___ daytime sleepiness
___ not refreshed in the morning ___ have to move legs when falling asleep

HEAD, EAR, EYES, NOSE

___ hearing loss ___ ringing in ears ___ vertigo (dizziness)
___ sinusitis ___ visual loss ___ trouble swallowing
___ cataracts ___ glaucoma ___ loss of smell ___ other

ENDOCINE (GLANDS)

___ diabetes ___ thyroid disorder ___ other

DERMATOLOGIC (SKIN)

___ rash ___ skin cancer ___ abnormal birthmarks
___ other

PULMONARY (LUNGS)

___ asthma ___ emphysema ___ difficulty breathing
___ pneumonia ___ sarcoidosis ___ lung cancer
___ tuberculosis ___ other

CARDIOVASCULAR (HEART, BLOOD VESSELS)

___ chest pain ___ high blood pressure ___ heart attack
___ heart failure ___ palpitations ___ heart rhythm problems
___ atrial fibrillation ___ leg swelling ___ blood clots in legs
___ poor circulation ___ high cholesterol ___ other

GASTROINTESTINAL (STOMACH/DIGESTION)

___ hiatal hernia ___ ulcers ___ gallbladder problems
___ hepatitis ___ cirrhosis ___ diverticulitis
___ diarrhea ___ constipation ___ black/bloody stools
___ pancreatitis ___ cancer ___ irritable bowel syndrome
___ reflux/heartburn ___ other

UROLOGIC (BLADDER/KIDNEYS)

___ blood in urine ___ kidney stones ___ cancer
___ prostate (men) ___ incontinence (loss of urinary control)
___ kidney failure ___ dialysis ___ Frequent nighttime urination
___ other

MUSCULOSKELETAL/RHEMATOLOGIC (BONES/JOINTS/MUSCLES)

___ arthritis ___ rheumatoid arthritis ___ lupus
___ aches in muscles ___ back pain ___ joint pain
___ osteoporosis ___ fibromyalgia ___ other

GYNECOLOGIC/FEMALE

___ endometriosis ___ abnormal menses ___ breast problems
___ cancer ___ recurrent miscarriages ___ other
___ are you pregnant Last menstrual cycle (if applicable) ____________

HEMATOLOGIC/BLOOD

___ anemia ___ sickle disease/trait ___ bleeding problems
___ leukemia/lymphoma ___ other

PSYCHIATRIC

___ depression ___ anxiety ___ mania/bipolar
___ schizophrenia ___ sadness/tearfulness ___ other

NEUROLOGIC (BRAIN/SPINAL CORD/NERVES)

___ headaches ___ previous stroke ___ difficulty with speech
___ head injury ___ weakness ___ numbness
___ difficulty walking ___ seizures ___ other

SURGERIES

DATE	PLACE	WHAT TYPE OF SURGERY

____

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FAMILY HISTORY

Please indicate the status of your 1st degree relatives as "L" living or "D" dead

Father __ Mother __ Brothers(s) ____ Sister(s) ____ Sons(s) _____ Daughters(s) ____

Do any of the following disorders run in your family? If so, please indicate by placing a corresponding letter for the appropriate relative by the diagnosis: F (father), M (mother), B (brother), S (sister), So (son), D (daughter) or O (other)

_____ high blood pressure _____ diabetes _____ heart attack _____ stroke
_____ cancer _____ psychiatric problems _____ nerve or muscle disease
_____ Alzheimer's Disease _____ tremor _____ Parkinson's disease
_____ seizures_____ headache/migraine _____ multiple sclerosis _____ other

MEDICATIONS:

DAILY:

MEDICATION DOSE TIMES A DAY

____
____
____
____
____
____
____
____

AS NEEDED:

____
____
____
____

ALLERGIES/SENSITIVITIES

DRUG REACTION

____
____
____
____

PERSONAL:

Have you ever smoked?: ______ Do you smoke now?:______

If so, how much do you smoke a day? ______________________________

Do you drink? _______________ How much a day? ______________________

How many caffeinated drinks a day? _____________________________________

Married? ____________________ Number of children? ____________________

Your occupation (past/present) ____

Thank you.