NEUROLOGY & NEUROSCIENCE ASSOCIATES, INC.
a division of unity health network

PERSONAL HISTORY FORM, page 1 of 2
Please complete both sides

Patient Name _____

Referred by_____ Family doctor _____
(first & last name) **(first & last name)**

Date of Birth _____ Height _____ Wt. _____ Right Left handed (circle one)

Medical problem I'm seeing a Neurologist / Sleep specialist for:_____

_____

Who else has evaluated you for this condition:_____ _

When:_____ **Where**:_____

Is this Work Related? _____ **YES** _____ **NO**

Your Past Medical History (check those that apply): ___A-fib __ Anemia __Anxiety (onset at age____) __ Arthritis
__ Asthma (allergy or exercise induced) __Cancer (type_____) __COPD __Coronary Artery Disease
__Depression (onset at age____) __Diabetes (onset at age____) __Emphysema __Headaches (onset at age___)
__ Heart attack (date_____) Hepatitis __Yes __No (A, B, C) __High Blood Pressure (onset at age____)
__High Cholesterol (onset at age____) __HIV/AIDS __Yes __No __ Hernia __Migraines (onset at age___)
__Pacemaker (date_____) __Reflux __Seizures (onset at age___) __ Sleep apnea (CPAP / BIPAP circle one)
__Stroke (date_____) __Thyroid Disease __Ulcer pressure_____ DME Co._____
__Head Trauma (due to, explain) _____

Other Medical problems: _____

Surgeries: (list all) _____

Hospitalizations or ER visits:_____
(past (1) year; location/facility)

Review of Systems: (**circle** those that apply to **YOU**):

1. CONSTITUTIONAL: fevers loss of appetite night sweats weight loss weight gain
2. EYES: blurry vision loss of vision double vision redness eye pain
3. EAR, NOSE, THROAT: snoring hearing loss-right/left ringing in the ears earache sinus trouble
4. CARDIOVASCULAR: palpitations chest pain fainting legs swelling unable to lie flat
5. RESPIRATORY: cough shortness of breath
6. GASTROINTESTINAL: indigestion nausea vomiting
7. GENITAL / URINARY: frequent urination incontinence bedwetting nighttime urination urgency
8. NEUROLOGIC: sleepiness tremors headaches dizziness numbness
9. PSYCHIATRIC: restless sleep depression anxiety forgetfulness loss of consciousness
10. ALLERGY: hay fever sinus headaches hives
11. ENDOCRINE: irregular menses fatigue hot/cold intolerance
12. MUSCULOSKELETAL: neck pain back pain leg pain joint pain osteoporosis osteopenia
13. HEMATOLOGIC: easy bleeding blood clots deep vein thrombosis pulmonary embolus blood transfusion
14. SLEEP: restless legs choking at night leg cramps insomnia

Please complete both sides

Have you had any of the following tests in the past 5 yrs? **(check those that apply)**

CT___ EEG___ EMG/NCT___ LABS___ MRI___ SLEEP STUDY___

Social History: (check those that apply)

Race: __Caucasian __African-American __Asian __Hispanic __American Indian/Alaskan Native

__ Native Hawaiian or Pacific Islander __Other: _____

Preferred Language if other than English_____

Occupation: _____ __Retired __Unemployed __Disabled __Student __Homemaker

If disabled, why_____

Marital Status: __Single __Married __ Significant Other __Widowed __Divorced __Separated

I live with: __Alone __Spouse __Significant Other __Children __Parents __Other_____

I live at: __My own home/apt __Group home __Senior Apartment __Assisted Living __Nursing home

Tobacco: __No __Yes ___Cigarettes/Cigars ____packs per day ___Smokeless Date Quit _____

Alcohol: __No __Yes _____drinks per week Date Quit _____

Caffeinated Beverages: __No __Yes _____cups per day

Recreational Drugs: __No __Yes What kinds and how often? _____

Exercise: __No __Yes Type and how often? _____

Living Will: __No __Yes Full Resuscitation Do Not Resuscitate No Vent Gen Med Care

Family History: Do any of your immediate family members suffer from: (**check those that apply**)

Immediate family members include parents, grandparents or siblings.

__Alcoholism __Alzheimer's __Attention Deficit __Cancer (type)_____

__Dementia __Diabetes __Heart Disease __High Blood Pressure __High Cholesterol

__Huntington's __Migraine __Multiple Sclerosis __Muscle Weakness __Narcolepsy

__Parkinson's __Restless Legs __Seizures __Sleep Apnea __Stroke

Adopted __No __Yes __Thyroid Disease

Mother: Living Date of Birth_____ Deceased Age _____ Unknown

Father: Living Date of Birth_____ Deceased Age _____ Unknown

Medication allergies: _____ None:_____

Pharmacies used name and where:_____

_____

Medications: (list both prescription & over the counter) _____ List attached

Medication name / strength / directions		Medication name / strength / directions