The Neurology Center
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PAST MEDICAL HISTORY

Patient Name____________________________ Referring Physician________________________________

Date_____________________________________ Date of Birth ______________________________

SURGICAL HISTORY (*Please check which apply to your past medical history*)
__ Tonsillectomy __ Appendectomy __ Gyn Surgery __ Hernia
__ Gallbladder __ Heart Surgery __ Cataract
Other Surgeries____

MEDICAL HISTORY (*Please check which apply to your past medical history*)
__ High Blood Pressure __ Diabetes __ Seizures
__ Stroke __ Migraine __ Heart Disease
□ Cancer (Type of Cancer)____
□ Other Medical or Neurologic Problems____

ALLERGIES TO MEDICATIONS____

CURRENT MEDICATIONS & DOSAGE REQUIREMENTS____

SOCIAL HISTORY **Smoking?** __ No __ Yes (If Yes, please list how many packs per day and for how many years you have smoked): _________ packs per day, for ______ year(s). Date Quit Smoking: __________________________

Alcohol? __ No __ Yes (If Yes, please indicate the number of drinks per day, number of years, and type(s) of alcohol used): _____ drink(s) per day for _____ year(s). Type(s) of Drinks: __ Beer __ Wine __ Mixed Drinks
__ Never Used Alcohol __ Hospitalized for Alcohol Use

EMPLOYMENT
Job Title_________________________________ ______ hours per day.
Levels of Stress: __ High __ Medium __ Low Exposures: __ Noise __ Chemicals __ Toxins
__ Fumes __ Gases __ Other: ____

EDUCATION Highest Level Achieved____

FAMILY HISTORY: (*please list those people in your family with the following illnesses*):
High Blood Pressure ____________________________ Heart Disease ________________________________
Diabetes ______________________________________ Cancer ______________________________________
Stroke____ Migraine _____________________________________
Seizures_______________________________________ Parkinson's ___________________________________
Alzheimer's ____________________________________ Other Neurologic Problems ____________________

My Primary Care Physician is: ____