

Patient Name: _____ Date: _____
 Date of Birth: _____ Referring Provider: _____
 Please describe the problem you are seeing the doctor for: _____

System Review (Please Check)		Yes	No	Health History (Please Check)		Yes	No
1. Bowel/Bladder Problems				1. Anxiety			
2. Difficulty sleeping				2. Blackouts			
3. Dizziness				3. Blood Clots			
4. Do you use a CPAP?				4. Depression			
5. Falls/Gait disturbance				5. Diabetes			
6. Headache				6. Headache/Migraine			
7. Memory Changes				7. Heart Conditions			
8. Numbness/Tingling				8. High Blood Pressure			
9. Recent Weight Change				9. High Cholesterol			
10. Seizures				10. Mental Disorder			
11. Trouble Swallowing				11. Pacemaker			
12. Trouble Talking				12. Seizures			
13. Vision Disturbance				13. Stroke			
14. Weakness				14. Thyroid Disorder			
Family History (Please list relationship) Do any family members have a history of:		Yes	No	Relationship	Surgery History Please list Major Surgeries & approximate dates:		
1. Cancer							
2. Carotid Disease							
3. Dementia							
4. Diabetes							
5. Heart Disease							
6. High Blood Pressure							
7. Migraine/Headache							
8. Parkinsons							
9. Peripheral Artery Disease							
10. Seizure							
11. Stroke							
12. Tremors							
Habits/Social History							
1. Have you ever smoke/chewed tobacco?				Packs/day _____ Years Smoked _____ Year Quit _____		Have you had any of the procedure performed listed below? If so, when and where?	
2. Do you follow a special diet?							
3. Do you use caffeine?				Amount/day _____		Yes	No
4. Do you use Alcohol?				Amount/day _____	Carotid Doppler's		
5. Do you have a history of substance use/addiction?					CT Scan		
6. Occupation _____					EEG		
7. Marital Status _____					EMG		
8. Which is dominant hand? <input type="checkbox"/> Right <input type="checkbox"/> Left					MRI Scan		

Bryan Physician Network

**NEUROLOGY ASSOCIATES
HEALTH HISTORY**



Place Patient Label Here

