Department of Neurology Dr. Joshua Buck

PATIENT HEALTH HISTORY Date: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

REASON FOR TODAY'S APPOINTMENT: _____

_____

MEDICAL ILLNESSES (Circle any illnesses you have or have had):

Bleeding problems	Heart disease	Muscle Disease	Stroke
Blood clots in lungs	High blood pressure	Neuropathy	Thyroid disease
Diabetes	High cholesterol	Seizures	Tremor
Glaucoma	Kidney stones	Sexually transmitted disease	Traumatic brain injury
Hearing loss	Multiple Sclerosis	Sleep Apnea	Vision Loss

Cancer(s): _____

Other(s): _____

If you have had any of the following, please provide the **type**, **number**, and **date(s)**:

Stroke: _____

Seizures: _____

OTHER SURGERIES (kind of operation): _____

_____

HOSPITALIZATION HISTORY (Other than for surgery): _____

_____

FAMILY HISTORY – Using the neurological conditions on left, please fill out the following:

Conditions:
Dementia
Headaches
Multiple sclerosis
Muscle disease
Neuropathy
Tremors
Stroke
Other

Relative	Conditions (see left)	Age Onset	If Deceased (Cause)
Father			
Mother			
Father's Parent's (M)			
(F)			
Mother's Parent's (M)			
(F)			
Brother (B) or ( )			
Sister (S) ( )			
( )			
( )			
( )			
Children: Son (S)			
Daughter (D)			
( )			
( )			

ALLERGIES: Offending Drugs or Foods (including aspirin, iodine, latex, etc.)

_____Reaction _____ _____Reaction_____

_____Reaction _____ _____Reaction_____

_____Reaction _____ _____Reaction_____

MEDICATIONS:

Please list any medicines (prescription or over-the-counter) or vitamins you take on a regular basis.

_____ _____ _____

_____ _____ _____

_____ _____ _____

PERSONAL HISTORY

Marital Status: (circle) Single Married Divorced Widowed

Name of persons living in your household:

Name/Relationship to you	Name/Relationship to you
_____	_____
_____	_____
_____	_____

Occupation: _____

Hobbies: _____

Exercise:	Frequency:_____	Type of exercise:_____
Alcohol:	Regular Basis:_____	Type/quantity: _____
	Quit Date:_____	Past use quantity:_____
Tobacco:	Packs per day: _____	How many years:_____ Quit Date:_____
	Use smokeless:_____	Cigars: _____
	Use Vape:_____	
Caffeine:	Regular Basis:_____	Type/quantity: _____
Sleep:	Average Hours:_____	
	Normal Weekday Bedtime:_____	Normal Weekday Time Waking Up:_____
	Normal Weekend Bedtime:_____	Normal Weekend Time Waking Up:_____

WOMEN ONLY:

Menstruate: (circle) Yes No

Last period:_____

Could you be pregnant? (circle) Yes No

Number of pregnancies:_____ Deliveries:_____

Miscarriages/abortions:_____ Living Children:_____

SYSTEMS REVIEW:
Please indicate if you have experienced **IN THE LAST 2 WEEK** any of the following:

GENERAL

Poor appetite	No	Yes
Fever	No	Yes
Chills	No	Yes
Fatigue	No	Yes
Sleep poorly	No	Yes

EYES

Double vision	No	Yes
Loss of vision	No	Yes

ENT

Sinusitis	No	Yes
Deafness	No	Yes
Ear pain	No	Yes

CARDIOVASCULAR

Chest pain	No	Yes
Fast heart	No	Yes
Irregular heartbeat	No	Yes
Swelling of feet, hands, face	No	Yes

RESPIRATORY

Shortness of breath	No	Yes
Cough	No	Yes
Coughing blood	No	Yes
Asthma	No	Yes

GASTROINTESTINAL

Nausea	No	Yes
Vomiting	No	Yes
Heart burn	No	Yes
Blood in stools	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Black stools	No	Yes

GENITOURINARY

Urinary frequency	No	Yes
Urinary incontinence	No	Yes
Pain in urination	No	Yes

MUSCULOSKELETAL

Back pain	No	Yes
Joint pain	No	Yes
Stiff neck	No	Yes

DERMATOLOGY

Rash	No	Yes

NEUROLOGICAL

Dizziness	No	Yes
Fainting/Loss of Consciousness	No	Yes
Trouble swallowing	No	Yes
Headaches	No	Yes
Paralysis/Weakness	No	Yes
Numbness	No	Yes

PSYCHIATRIC

Depression	No	Yes
Anxiety	No	Yes
Suicidal Thoughts	No	Yes

ENDOCRINE

Warmer than others	No	Yes
Colder than others	No	Yes
Weight change (>10 lbs)	No	Yes

HEMATOLOGY

Easy bruising	No	Yes
Bleeding gums	No	Yes
Prolonged bleeding	No	Yes

ALLERGY

Hives or rash	No	Yes
Possible HIV exposure	No	Yes

REMARKS:_____

_____

_____