HEALTH HISTORY

Bethesda Neurology, LLC

NAME:_____ **Today's Date**:_____

Age:_____ **Birthdate**:_____ **Referring physician:**_____

Reason(s) for today's visit?_____

_____

_____

Past Medical History (Check any medical conditions past and/or present)

☐ Stroke / TIA	☐ Diabetes	☐ Heart Valve Replacement	☐ Thyroid disease
☐ Migraine	☐ Macular degeneration	☐ Tuberculosis	☐ Sarcoidosis
☐ Multiple sclerosis	☐ Glaucoma	☐ Lung disease	☐ Cancer:_____
☐ Parkinson's disease	☐ Cataract surgery	☐ Liver disease	☐ Currently pregnant
☐ Loss of consciousness	☐ Heart disease	☐ Arthritis	☐ Prostate disease
☐ Epilepsy/seizures	☐ Pacemaker	☐ Lupus	☐ Sickle cell disease
☐ Head injury	☐ High blood pressure	☐ Kidney disease	☐ HIV or other STD
☐ Neuropathy	☐ High cholesterol	☐ Ulcer	☐ Other(s):_____

Other Symptoms (Please List on Back of Page)

Review of Symptoms (Please check any of the following symptoms you are experiencing)

Neurological:

☐ Double vision	☐ Headache	☐ Vertigo/spinning	☐ Confusion
☐ Blurred vision	☐ Muscle weakness	☐ Dizzy/lightheaded	☐ Memory loss
☐ Eye pain	☐ Speech problems	☐ Walking problems	☐ Tingling /numbness
☐ Eyelid drooping	☐ Swallowing difficulties	☐ Balance problems	☐ Tremors or tics

Cardiovascular:	**ENT:**	**Genitourinary:**	**Psychologic:**
☐ Chest pain	☐ Hearing loss	☐ Incontinence	☐ Depression
☐ Irregular pulse	☐ Ringing in ear(s)	☐ Pain during urination	☐ Anxiety / nervousness
☐ Poor circulation	☐ Nose bleeds	☐ Blood in urine	☐ Hallucinations
☐ Heart murmur	☐ Sinus problems	☐ Frequent urination	☐ Fatigue

General:	**Dermatology:**	**Endocrine:**	**Pulmonary:**
☐ Weight change	☐ Rash	☐ Too hot or cold	☐ Cough
☐ Fever/chills	☐ Birth marks	☐ Breast discharge	☐ Shortness of breath
☐ Sleep disturbance	☐ Skin lesion(s)	☐ Irregular periods	☐ Wheezing

Hematology:	**Gastrointestinal:**	**Gastrointestinal:**	**Musculoskeletal:**
☐ Easy bruising	☐ Abdominal pain	☐ Nausea/vomiting	☐ Neck/low back pain
☐ Anemia	☐ Diarrhea/constipation	☐ Blood in stool	☐ Swollen joints

HEALTH HISTORY (Continued)

Bethesda Neurology, LLC

FAMILY History (Please check any that apply)

☐ Headaches/migraines	☐ Multiple sclerosis	☐ Diabetes	☐ Thyroid
☐ Stroke	☐ Nerve/muscle disease	☐ Heart disease	☐ Alcoholism/addiction
☐ Aneurysms	☐ Dementia	☐ Cancer:_____	☐ Sickle cell disease
☐ Seizures/Epilepsy	☐ High blood pressure	☐ Arthritis	☐ Other:_____

Medications / Dosage

Allergies (medication, foods, latex, etc.)

Hospitalizations / Surgeries (Please include dates)

Social History

Tobacco User? O Yes O No O Quit (when?)_____ If yes, how many packs per day?_____

Alcohol (beer/wine/liquor)? O Yes O No O Quit (when?)_____ If yes, how many drinks per day?_____

Drug Use? O Yes O No O Quit (when?)_____

Caffeinated Beverages? O Yes O No If yes, how many cups/cans per day?_____

Occupation:_____

Please List Other Symptoms

Please List Any Questions for the Doctor

Reviewed: _____