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

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

Patient Name _____ Date of Birth _____

Referred by_____

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

_____

___A-fib __ Anemia __Anxiety __ Arthritis __ Asthma __Blood Clots __Cancer __COPD
__Coronary Artery Disease __Depression __Diabetes __DVT __Emphysema __Headaches __ Heart attack
__Hepatitis __Hernia __High Blood Pressure __High Cholesterol __HIV/AIDS __Hypersomnia
__Huntington's Disease __Migraines __Multiple Sclerosis __Narcolepsy __Neuropathy
__Pacemaker __Parkinson's Disease __Pulmonary Embolism __Reflux __Seizures __Stroke (date _____)
__TB __Thyroid Disease __Tremors __Trigeminal Neuralgia __Ulcer
__Sleep apnea (CPAP / BIPAP circle one) pressure _____ DME Co. _____

Surgeries: (lifetime)_____

_____

_____

Hospitalizations or ER visits in the last 6 months:_____

_____

Have you had any of the following tests in the past 5 years? (Check those that apply)
__CT __ EEG __ EMG/NCT __ Labs __ MRI

Review of Systems: (**circle** those that apply to **YOU in the LAST WEEK**):

CONSTITUTIONAL: Fevers Loss of Appetite Night Sweats Weight Loss Weight Gain
SLEEP: Restless Legs Choking at Night Leg Cramps Insomnia
ALLERGY: Hay Fever Sinus Headaches Hives
EYES: Blurry Vision Loss of Vision Double Vision
EAR, NOSE, THROAT: Snoring Hearing Loss Ringing in the Ears Sinus Problems
ENDOCRINE: Irregular Menses Fatigue Hot/Cold Intolerance
RESPIRATORY: Cough Shortness of Breath
CARDIOVASCULAR: Palpitations Chest Pain Fainting Legs Swelling
GASTROINTESTINAL: Indigestion Nausea Vomiting
HEMATOLOGIC: Easy Bleeding Blood Clots Deep Vein Thrombosis Pulmonary Embolus Blood Transfusion
GENITAL / URINARY: Frequent Urination Incontinence Bed Wetting Nighttime Urination Urgency
MUSCULOSKELETAL: Neck Pain Back Pain Leg Pain Joint Pain
NEUROLOGIC: Sleepiness Tremors Headaches Dizziness Numbness
PSYCHIATRIC: Restless Sleep Anxiety Forgetfulness Feeling Depressed

Patient Name _____

Race: (please circle one) African-American Asian American Indian Alaskan Native Caucasian Hispanic Native Hawaiian Pacific Islander or Other: _____

Preferred Language if other than English_____

Occupation: _____ Full Time or Part Time __Retired __Unemployed __Student __Homemaker

Disabled: Why_____

Marital Status: Divorced Married Separated Single Widowed

Live with: Alone Children Parents Significant Other Spouse Group Home Nursing Home

Smoker: ___Never ___Former (Quit Date _____) ___ Current ___Cigarettes/Cigar ___Packs per Day

Alcohol: ___Never ___Occasional ___Yes; Drinks per Week _____

Caffeinated Beverages: ___Never ___Occasional ___Yes; Drinks per Day _____

Recreational Drugs: ___Never ___Occasional ___Yes; Type_____

Exercise: ___ No ___Yes; Type and how many times per week _____

Living Will: ___ No ___ Yes (Type: DNR, Full Resuscitation, no Vent, Gen Med Care)

Are you Adopted: ___ No ___ Yes

Family History: Do any of your Father, Mother, or Siblings have any of the following:
Please mark M for Mom, D for Dad and S for 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

Mother: Living Date of Birth_____ Deceased Age _____

Father: Living Date of Birth_____ Deceased Age _____

Medication allergies: _____

Pharmacies used, name and where: _____

_____

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

Medication name / Strength / Directions		Medication name / Strength / Directions