

*Neurology Health History Questionnaire*

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Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Who referred you to a Neurologist: \_\_\_\_\_ Name of Primary Care Physician: \_\_\_\_\_

What condition or symptoms are you being seen for today?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What types of testing have you had done for this condition?  MRI  CT  Lab/Blood  Other: \_\_\_\_\_

When and where did you have the testing?  
\_\_\_\_\_

List any problems with the following:

Head: \_\_\_\_\_  Stomach: \_\_\_\_\_

Eyes, Ears, Nose, Throat: \_\_\_\_\_  Intestines: \_\_\_\_\_

Neck or Back: \_\_\_\_\_  Liver/gallbladder: \_\_\_\_\_

Heart: \_\_\_\_\_  Genitalia: \_\_\_\_\_

Lungs: \_\_\_\_\_  Bladder/Kidneys: \_\_\_\_\_

Bones/Joints: \_\_\_\_\_  Females: date of last period: \_\_\_\_\_

Do you Smoke?  No  Yes, \_\_\_\_\_ Packs per day? \_\_\_\_\_ Age started: \_\_\_\_\_  Date Quit: \_\_\_\_\_

Do you Drink?  No  Yes, \_\_\_\_\_ How much? \_\_\_\_\_

Family History of Neurological Diseases  No  Yes

If yes, please explain: \_\_\_\_\_

Have you had any PRIOR serious illness or injury?  No  Yes

If yes, please explain: \_\_\_\_\_

Have you had surgery in last 10 years?  No  Yes

Type of surgery: \_\_\_\_\_ Date: \_\_\_\_\_ Hospital: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Daily Medications Including OTC (over the counter): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_