DALLAS NEUROLOGICAL ASSOCIATES

NAME: _____ **DATE:** _____

PAST MEDICAL HISTORY

(CONFIDENTIAL)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

MEDICINES — Write name and mg (size), how many you take at a time and how many times a day you take it.

Name of Medicine	MG (dosage size)	How many at a time?	No. per day

Do you have any allergies to medicine, and if so, what type of reaction (rash, etc.)? _____

_____

Family History — list if any siblings, parents, children, grandparents, aunts or uncles have or have had any of these (please specify who for each answer):

Cancer: _____ What type:? _____

Heart attack: _____ At what age? _____

Stroke: _____ At what age? _____

Diabetes: _____

Headaches: _____

High blood pressure: _____

Multiple Sclerosis: _____

Alzheimer's: _____

Parkinson's: _____

Any other neurological disease: _____

_____

_____

SOCIAL HISTORY

1. Do you or have you ever smoked? If so, how much and for how many years: _____
2. Do you or have you ever consumed alcohol (beer, wine, liquor)? If so, how much, how often, and for how many years? _____
3. Do you or have you ever used illicit drugs (cocaine, marijuana, etc.)? Please name what you use and how often. _____
4. What is your occupation? _____
5. With whom do you live? _____

REVIEW OF SYMPTOMS

Have you recently had:

A. Fever? _____

B. Unexplained weight loss? If so, how much and over what time period? _____

C. Sleep problems? If so, what? _____

Have you had any of the following tests, and if so, what body part, what were the results, and where was the test performed?

MRI _____

Cat Scan _____

EEG _____

Please indicate any of the following illnesses you've had:

Asthma _____
Emphysema _____
Tuberculosis (TB) _____
Coughing up blood _____
Duodenal or stomach ulcer _____
Blood in bowel movements _____
Blood in urine _____
Kidney disease _____
Kidney stones _____
Rheumatoid arthritis _____
Osteoarthritis _____
Broken bones (where?) _____
Cancer (what type?) _____
Depression _____
Diabetes _____
Lupus _____
Anemia _____

Bleeding disorder _____
Glaucoma _____
Macular degeneration _____
Thyroid disease _____
Vitamin B12 deficency _____
Hepatitis _____
Skin disease _____
Allergies _____
Heart attack _____
High blood pressure _____
High cholesterol / high triglycerides _____
Angina _____
Irregular heartbeat _____
Anxiety / panic attack _____
Other: _____
_____
_____

What was the result and date of your last mammogram? _____

What was your last PSA level (prostate screen)? _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her employ responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Signature _____ Date _____