Neurologic Associates

1359 N MOUNT AUBURN ROAD
CAPE GIRARDEAU, MO 63701
P: 573-651-3188 | F: 573-651-3048

HEALTH HISTORY FORM

(Please Print)

PATIENT NAME: _____ **DOB:**_____ **DATE:**_____

Please Check boxes if you have a history of any of the following:

PAST MEDICAL HISTORY

☐ AIDS/HIV	☐ Heart Disease	☐ Neuropathy
☐ Anemia	☐ Hepatitis (A, B, C)	☐ Obstructive Sleep Apnea
☐ Arthritis (Type:_____)	☐ High Cholesterol	☐ Irritable Bowel Syndrome
☐ Asthma	☐ Hypertension	☐ Seizures
☐ Blood Clotting Disorder	☐ Insomnia	☐ Stroke
☐ Cancer: (Type:_____)	☐ Kidney Disease	☐ Tuberculosis
☐ COPD/Emphysema	☐ Liver Disease	☐ Urinary Problems
☐ Crohn's or Ulcerative Colitis	☐ Macular Degeneration	☐ Other:_____
☐ Depression/Anxiety	☐ Pulmonary Embolism	☐ _____
☐ Diabetes (Type:_____)	☐ Thyroid Problems	☐ _____
☐ Glaucoma	☐ Lupus	☐ _____
☐ Headaches	☐ Migraines	☐ _____

PAST SURGICAL HISTORY

☐ Angioplasty _____	☐ Gallbladder _____	☐ Neck Surgery _____
☐ Appendectomy _____	☐ Gastric Bypass _____	☐ Pacemaker _____
☐ Back Surgery _____	☐ Heart Bypass _____	☐ Prostate Surgery _____
☐ Bowel Resection _____	☐ Hemorrhoids _____	☐ Thyroidectomy _____
☐ Breast Surgery _____	☐ Hernia _____	☐ Tonsillectomy _____
☐ Carpal Tunnel Surgery _____	☐ Hip Surgery _____	☐ Tubal Ligation _____
☐ Cataracts _____	☐ Hysterectomy _____	☐ Vasectomy _____
☐ Coronary Stenting _____	☐ Knee Surgery _____	☐ Vascular Surgery _____
☐ Other: _____	☐ _____	☐ _____

Have you had any falls in the last year? Yes ☐ No ☐ If so, how many times? ___ Did it result in an injury? Yes ☐ No ☐

SOCIAL HISTORY

Highest level of education completed: ☐ GED ☐ High School ☐ Vocational Tech ☐ College

Employment:_____

Hand dominance: □ Right □ Left □ Ambidextrous

Do you use tobacco? □ No □ Yes □ Former | □ Cigarettes □ Smokeless □ Vapor | How much used daily:_____

Do you drink caffeine? □ No □ Yes | □ Coffee □ Soda □ Tea | How much used daily:_____

Do you drink alcohol? □ No □ Yes □ Former | □ Wine □ Beer □ Liquor | How much used daily: _____

Illicit Drug Use? □ No □ Yes Type:_____

ALLERGIES

☐ Amoxicillin ☐ Ibuprofen ☐Latex ☐ Shellfish ☐ X-Ray Dye ☐ Other:_____
☐ Aspirin ☐ Iodine ☐Penicillin ☐ Sulfa ☐ Other: _____

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

FAMILY HISTORY (PLEASE NOTE WHETHER YOUR MOTHER, FATHER, BROTHER OR SISTER HAVE ANY OF THE FOLLOWING)

	Relation		Relation		Relation
☐ ALS	_____	☐ Diabetes	_____	☐ Seizure	_____
☐ Alzheimer's Disease	_____	☐ Heart Disease	_____	☐ Stroke	_____
☐ Asthma	_____	☐ High Blood Pressure	_____	☐ Thyroid Disease	_____
☐ Cancer (Type_____)	_____	☐ High Cholesterol	_____	☐ Other	_____
☐ Dementia	_____	☐ Parkinson's Disease	_____	☐ Unknown (Adopted)	

MEDICATIONS

Pharmacy Name: _____ **Location**: _____

Name	***Dosage***	***How often taken***

How would you prefer to be notified of appointment? **(Pick One)** ☐ Text ☐ Email

Patient Signature: _____ **Reviewed:** _____