Banner Health®

NEW PATIENT MEDICAL HISTORY
ADULT NEUROLOGY

Patient Name: _____ **Date of Birth:** _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): _____

Referring Physician

Name: _____ Phone #: _____

Address: _____ Fax #: _____

ALLERGIES

❑ No Known Allergies List any allergies and intolerances to **medications, food or the environment.**

Allergy	Reaction

Are you allergic to IV contrast? ❑ Yes ❑ No If yes, what is your reaction? _____

MEDICATIONS

❑ Not taking any medications

List any medications, vitamins, supplements, and over the counter medications you are taking, with dose and how often.

Medication Name	Dose	How often?

Are you on aspirin or a blood thinner? ❑ Yes ❑ No If yes, medication with dose and frequency: _____

If no, has a physician advised you not to take aspirin? ❑ Yes ❑ No

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9999-0146
(01/2017)

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MEDICAL HISTORY

What **medical** problems have you had? Please mark **all** that apply:

	Anxiety		Depression		Heart failure		Obstructive sleep apnea
	Asthma		Diabetes		High cholesterol		Osteoarthritis
	Atrial fibrillation		Emphysema/bronchitis		High blood pressure		Rheumatoid arthritis
	Brain aneurysm		Head injury		Irregular heart beat		Seizures / epilepsy
	Coronary artery disease		Heart attack		Neuropathy		Stroke / TIA
	Dementia						

Other medical problems:

Have you had any recent hospitalizations or ER visits (provide dates and reason below)?

Date	Reason	Date	Reason

SURGICAL HISTORY

List all prior surgeries and the year. ❑ **No prior surgeries**

Year	Type of Surgery		Year	Type of Surgery
	Back surgery			Neck surgery – Cervical spine surgery
	Brain surgery			Pacemaker / AICD
	Carotid artery surgery			Tonsillectomy / Adenoidectomy
	Coronary artery bypass graft/ stent			

Other surgeries:

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FAMILY HISTORY

List health conditions for each family member. Please include diabetes, heart disease, high blood pressure, stroke, cancer, mental illness, or any neurological disorder.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Brothers				
Sisters				
Daughter				
Son				

Any Additional Pertinent Family History: _____

_____

SOCIAL HISTORY

Tobacco/smoking status:	❑ Never				
	❑ Current	Type	Amount	Duration	
	❑ Former	Type	Amount	Duration	
Do you use alcohol?	❑ No	❑ Yes	Type	Amount	Frequency
Do you use recreational drugs?	❑ No	❑ Yes	Type	Amount	Frequency
Do you use Caffeine?	❑ No	❑ Yes	Type	Amount	Frequency

Occupation _____ Employer _____ How long? _____

Previous occupations: _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Partnered

Highest level of education: _____

Are you currently pregnant or planning on becoming pregnant? ❑ Yes ❑ No

Are you currently breastfeeding? ❑ Yes ❑ No

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REVIEW OF SYSTEMS

In the last six weeks, have you experienced any of the following:

CONSTITUTIONAL			GENITOURINARY			PSYCHIATRIC		
Chills	Yes	No	Blood in urine	Yes	No	Anxiety	Yes	No
Fatigue	Yes	No	Painful urination	Yes	No	Depression	Yes	No
Fever	Yes	No	Polyuria (urinating large volumes)	Yes	No	Insomnia	Yes	No
Malaise	Yes	No	Urinary frequency	Yes	No	**SKIN**		
Night sweats	Yes	No	Urinary incontinence	Yes	No	Contact allergies	Yes	No
Weight gain	Yes	No	Urinary retention	Yes	No	Hives	Yes	No
Weight loss	Yes	No	**REPRODUCTIVE**			Itching	Yes	No
HEENT			Abnormal pap	Yes	No	Mole change	Yes	No
Ear drainage	Yes	No	Breast discharge	Yes	No	Rash	Yes	No
Ear pain	Yes	No	Breast lump	Yes	No	Skin lesion	Yes	No
Eye discharge	Yes	No	Dysmenorrhea	Yes	No	**MUSCULOSKELETAL**		
Eye pain	Yes	No	Hot flashes	Yes	No	Back pain	Yes	No
Hearing loss	Yes	No	Irregular menses	Yes	No	Joint pain	Yes	No
Nasal drainage	Yes	No	Painful intercourse	Yes	No	Joint swelling	Yes	No
Sinus pressure	Yes	No	Vaginal discharge	Yes	No	Muscle weakness	Yes	No
Sore throat	Yes	No	**METABOLIC/ ENDOCRINE**			Neck pain	Yes	No
Vision changes	Yes	No	Brittle hair	Yes	No	**HEMATOLOGIC**		
RESPIRATORY			Brittle nails	Yes	No	Easy bleeding	Yes	No
Chronic cough	Yes	No	Cold intolerance	Yes	No	Easy bruising	Yes	No
Cough	Yes	No	Excessive hunger	Yes	No	Lymphadenopathy	Yes	No
Known TB exposure	Yes	No	Excessive thirst	Yes	No	**IMMUNOLOGIC**		
Shortness of breath	Yes	No	Hair changes	Yes	No	Environmental allergies	Yes	No
Wheezing	Yes	No	Heat intolerance	Yes	No	Food allergies	Yes	No
CARDIOVASCULAR			Hirsutism	Yes	No	Seasonal allergies	Yes	No
Chest pain	Yes	No	**NEUROLOGICAL**					
Claudication (pain in extremities)	Yes	No	Dizziness	Yes	No			
Edema (swelling)	Yes	No	Extremity numbness	Yes	No			
Palpitations	Yes	No	Extremity weakness	Yes	No			
GASTROINTESTINAL			Gait disturbance	Yes	No			
Abdominal pain	Yes	No	Headache	Yes	No			
Blood in stool	Yes	No	Memory loss	Yes	No			
Change in stools	Yes	No	Seizures	Yes	No			
Constipation	Yes	No	Tremors	Yes	No			
Diarrhea	Yes	No						
Heartburn	Yes	No						
Loss of appetite	Yes	No						
Nausea	Yes	No						
Vomiting	Yes	No						

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