SOUTH FLORIDA NEUROLOGY ASSOCIATES, P.A.

PATIENT MEDICAL HISTORY

Name _____ **Age** _____ **Left or Right Handed (circle)**

Primary/Referring Physician _____ **Phone** _____

Chief Complaint (Why are you here?) _____

Describe briefly the history of your problem: _____

_____

Please mark "X" if you have had any of the following:

__Back Pain	__Diarrhea	__Hearing Loss	__Pains	__Tremors
__Bladder Changes	__Dizziness	__Fever	__Palpitations	__Uncoordination
__Blurred Vision	__Double Vision	__Memory Loss	__Paralysis	__Unsteadiness
__Confusion	__Fainting	__Muscle Wasting	__Ringing in Ears	__Weight Loss/Gain
__Constipation	__Involuntary Movements	__Neck Pain	__Edema	__Sleep Disturbance
__Convulsion	__Headaches	__Numbness	__Tingling	__Loss of Appetite
__Rash	__Depression	__Insomnia	__Cough	__Shortness of Breath
__Chest Pain	__Anemia	__Loss of Smell		

Allergies: _____

Past Medical History (please list all medical problems) _____

_____

_____

Do you have a pacemaker or defibrillator? ___Yes ___No **Which?**_____

Hospitalizations/Surgeries (Dates & Reasons): _____

_____

Please mark "X" next to any conditions that you have now or have had in the past:

__Diabetes __High Blood Pressure __Head Injury __High Cholesterol __Heart Disease

__Seizures __ Stroke __Other (Explain):_____

Please list all medications including vitamins, supplements & herbal medicines that you are currently taking with dosages:

_____

_____

Family Medical History (Please list medical problem and family member affected): _____

_____

Do you smoke? ___Yes ___No **If yes, how much?** _____ **For how long?** _____

Do you drink alcohol? ___Yes ___No **If yes, how much?** _____ **How often?** _____

Do you use Marijuana, Cocaine and/or any unprescribed drugs? ___Yes ___No **If yes, which ones?** _____

Ethnicity? ___Hispanic or Latino ___ NOT Hispanic or Latino **Race:** _____

Occupation (Please indicate if retired.) _____

Additional comments or specific questions: _____

_____

I have answered the questions truthfully and to the best of my knowledge, without intent to falsify information. I understand that incorrect information I may have provided could affect recommended treatment and ultimately affect the course and outcome of my medical condition.

_____ _____ _____

Patient's Name (Print) Date Patient's Signature