

Asheville Neurology Specialists, P.A.
Health Questionnaire

Chart # _____

Date _____ Name _____ Age _____
Right or Left handed _____ Height _____ Weight _____
Referred By _____ Personal Physician _____

What is the reason for your visit today? _____
If result of an ACCIDENT, give date (s) and describe: _____

Are you employed now? _____ Last day worked _____ Occupation _____
Job Duties _____ Heavy lifting yes _____ or no _____

PAST MEDICAL HISTORY

Please list any medical problems for which you regularly see a doctor such as high blood pressure, diabetes, lung disease, etc. _____

Have you tested positive for TB _____yes _____no Hepatitis A, B or C _____yes _____no
Surgical: (Please list all surgeries with dates even if unrelated to today's visit) _____

Medications: Please list all medications and dosage including nonprescription pain relievers and vitamin supplements)

Name of Medication/Vitamin	Dosage	Frequency of dose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies and Reactions _____

Family Medical History (List ages and diseases)

	Age	Disease
Mother	_____	_____
Father	_____	_____
Sibling (s)	_____	_____
Children	_____	_____
Other Relatives	_____	_____

Social: Marital Status _____ Tobacco Use _____ Alcohol _____ Illegal Drugs _____

Review of Systems (Check all that apply below if you have experienced any recent problems in the following categories)

- General:** Unusual Weight loss or gain _____ Fever _____ Fatigue _____
Skin: History of skin cancer _____ History of Rash _____
Eyes: Eye Pain _____ Blurred Vision _____ Double Vision _____
Ears, Nose, Throat: Hearing loss _____ Sinusitis _____ Ringing in ears _____
Neck: Neck Stiffness _____
Resp: Asthma _____ Cough _____ Shortness of breath _____
Breast Disease: History of breast disease _____
CV: History of coronary artery disease _____ Chest pain _____ Palpitations _____
GI: Abdominal pain _____ Constipation _____ Diarrhea _____ Nausea _____ Vomiting _____ Bleeding ulcer _____ Bloody Stools _____
GU: Frequency of unination _____ Loss of bladder control _____ Blood in urine _____ Burning urination _____
History of nocturnal urination _____ impotence _____
Musculoskeletal: Joint pain/Arthritis _____ Muscle Cramps _____ Muscle weakness _____
Neurological: Memory problems _____ Dizziness _____ Headaches _____ Incoordination or clumsiness _____
Loss of balance _____ Blackouts _____ Numbness and tingling _____ Convulsions _____
_____ Confusion _____ Visual Changes _____ Weakness _____ Change in voice _____
Shaking, tremor or jerking _____
Psychological: Depression _____ Insomnia _____ Anxiety _____
Endocrine: Thyroid Disease _____ Diabetes _____
Hematologic: History of free bleeding/easy bruising _____ Anemia _____

Is there any other information you would like us to know to assist with your problem?
