Account # _____

**Asheville Neurology Specialists, PA**
**Medical Health Questionnaire**

Date: _____ Name: _____ DOB: _____ Age:_____ Right/Left Handed Male/Female Height: _____ Weight: _____ Referred by: _____ Personal Primary Care Physician: _____ What is the reason for your visit today? _____ If result of an ACCIDENT, give date(s) and describe _____

**PAST MEDICAL HISTORY:** Please list any medical problems for which you regularly see a doctor such as high blood pressure, diabetes, lung diseases, and etc. _____
_____

Have you tested positive for TB □ yes □no Hepatitis A, B, or C □yes □no Surgical History *(Please list all surgeries with dates even if unrelated to today's visit):* _____
_____

**PAST FAMILY MEDICAL HISTORY:**

| | Age | Living/Deceased | Disease(s) |
|---|---|---|---|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Sibling(s) | _____ | _____ | _____ |
| Children | _____ | _____ | _____ |
| Children | _____ | _____ | _____ |
| Other Relatives | _____ | _____ | _____ |

**PAST NEUROLOGICAL FAMILY HISTORY:** □ No family history of neurological illness □ Alzheimer's Disease □ Brain Cancer □ Cerebellar Ataxia □Epilepsy □Guillain-Barre Syndrome □Huntington's Disease □Mental Retardation □Migraine □Multiple Sclerosis □Myasthenia □Parkinson's □ Seizures □Peripheral Neuropathy

**SOCIAL HISTORY**

Alcohol use: □ Never □ Occasional □ Heavy Tobacco Use: □ Never ____ Packs/Day □ Quit
Illegal Drug Use: □ No □Yes (*Please explain)* _____ Living Situation: □Single □ Married □ Widowed
Caregiver *(if applicable*) _____ Current Work/Employment Status: _____ Most recent Primary Occupation_____
**Name of Pharmacy**_____**Phone Number**_____

**MEDICATIONS** *(Include prescription, herbal, over the counter and vitamins) Use reverse side if needed*

| Name of Medication | Dosage | Frequency |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**ALLERGIES/REACTIONS**: _____No known allergies _____ Medications _____Seafood/Food *(If you marked allergy to medications, please list medicine(s)* _____ *Reaction*: _____

**REVIEW OF SYSTEMS** *(Please circle all that apply below if you have experienced recent problems)*

| | |
|---|---|
| **General:** | Unusual Weight loss or gain Fever Fatigue |
| **Skin:** | History of Skin Cancer History of Rash |
| **Eyes:** | Eye pain Blurred Vision Double Vision Other Visual Disturbances |
| **Ears, Nose, and Throat:** | Hearing Loss Sinusitis Ringing in ears |
| **Neck:** | Neck Stiffness |
| **Respiratory:** | Asthma Cough Shortness of Breath |
| **Breast Disease:** | History of Breast Disease |
| **Cardiovascular:** | History of Coronary Artery Disease Chest Pain Palpitations |
| **Gastrointestinal:** | Abdominal Pain Constipation Diarrhea Nausea Vomiting Bleeding Ulcer Bloody Stools |
| **Genitourinary:** | Frequency of Urination Loss of Bladder/Bowel Control Blood in urine Burning with Urination History of Nocturnal Urination Impotence |
| **Musculoskeletal:** | Joint Pain/Arthritis Muscle Cramps Muscle Weakness |
| **Neurological:** | Memory Problems Dizziness Headaches Lack of coordination 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 neurological/medical problem: _____
_____