(Confidential) Patient Name: _____________

The NeuroLife Consortium
Cynthia A. Sloan, DO
Patient Health History

Patient Name: ______________________________________Today's Date:__________________________
Age: _________________ Birth Date: ______________________Race_____________________________
What is your reason for initial visit? ____
Referring Dr. & Telephone # ________________________Family Dr. & Telephone #_________________
Pharmacy Name, Location, & phone # ____
○ Right handed / ○ Left handed

Symptoms: Check symptoms you currently have or had in the past year. (Update form annually)

GENERAL
- ○ Anxiety/Depression
- ○ Dizziness
- ○ Fainting/Blackouts
- ○ Falling/Difficulty walking
- ○ Forgetfulness
- ○ Headache
- ○ Imbalance
- ○ Loss of Sleep
- ○ Muscle Pain of _____________
- ○ Numbness of ______________
- ○ Slurred Speech

GASTROINTESTINAL
- ○ Appetite Poor
- ○ Bowel Changes
- ○ Excessive Hunger
- ○ Excessive Thirst
- ○ Nausea/ Vomiting

EYE/EARS/NOSE
- ○ Blurred/Double Vision
- ○ Vision-Flashes/Halos
- ○ Difficulty Swallowing
- ○ Hay fever/Allergies
- ○ Loss of Hearing
- ○ Ringing in Ears
- ○ Earache

CARDIOVASCULAR
- ○ High Blood Pressure
- ○ Irregular Heart Beat
- ○ Low Blood Pressure
- ○ Poor Circulation

SKIN
- ○ Bruise Easily
- ○ Itching
- ○ Rash

OTHER MEDICAL
Diagnosis/Disorders:
____
____

Female Patients:

Date of Last Menstrual Period:
____
Are you Pregnant? ________
Due Date if Yes____________
Number of Children________
Number of Pregnancies______

CONDITIONS: Check conditions you have or had in the past (please indicate HX for history)

- ○ AIDS/ HIV
- ○ Alcoholism
- ○ Anemia
- ○ Anorexia
- ○ Arthritis
- ○ Asthma
- ○ Bell's Palsy
- ○ Bleeding Disorders
- ○ Brain Aneurysm
- ○ Bulimia
- ○ Brain Cancer
- ○ Cancer of the… ___________________
- ○ Chemical Dependency
- ○ Confusion
- ○ COPD
- ○ Diabetes, I or II
- ○ Dystonia
- ○ Emphysema
- ○ Epilepsy/Seizures
- ○ Goiter
- ○ Gout
- ○ Head Trauma
- ○ Heart Disease
- ○ Hepatitis A, B, C
- ○ Herpes/Shingles
- ○ High Cholesterol
- ○ Kidney Disease
- ○ Liver Disease
- ○ Memory Loss
- ○ Migraine Headaches
- ○ Mononucleosis
- ○ Multiple Sclerosis
- ○ Pace Maker
- ○ Parkinson's Disease
- ○ Polio
- ○ Psychiatric Care
- ____________________
- ○ RLS (restless leg syndrome)
- ○ Severe Injury from Car Accident
- ○ Spine Trauma
- ○ Stroke
- ○ Suicide Attempt
- ○ Syphilis
- ○ Thyroid problems
- ○ Tremor/Shaking
- ○ Tuberculosis
- ○ Ulcers/IBS

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HEALTH HABITS: Check (✓) which substance you use and describe how much you use.

- Caffeine___________________________________
- Tobacco____________________________________
- Drugs______________________________________
- Alcohol_____________________________________
- Other______________________________________

Family History: Fill in Health Information about your family.

Relation To Patient	Age	Health Status G – Good F – Fair P - Poor	Age at Death	Cause of Death	Check if your blood relative had any of the following disease/illness (✓)		Relationship to you
Father						Parkinson's Disease	
Mother						Migraines	
Brothers						Cancer	
						Alzheimer's/ Dementia	
						Heart Disease	
						Multiple Sclerosis	
						High Blood Pressure	
Sisters						Stroke	
						Seizures	
						Depression	
						Other Psychological Illness	
						Other Neurological Illness	
						Other Pertinent	

Surgical Procedures:

Year	Hospital	Procedure/Surgery Performed

Pregnancy History:

Year of Birth	Sex Of Child M or F	Complications, of Any

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MEDICATIONS: List medication you are **CURRENTLY** taking (including over the counter meds/vitamins/herbs/etc). **Also list the dosage/mg and directions (how often medication is taken).**

Medication	Strength	Directions taken	Allergies	Reactions

Immunizations:

Vaccine	**Date Administered**	**Dose**	**Refusal /Reason**
Influenza			
Human Papillomavirus			
Tetanus			
Diptheria			
Pertusis			
Varicella			
Pneumococcal			
Zoster			

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Patient Authorization:

I certify that the above information is correct to the best of my knowledge, and/or I delegate Dr. Sloan's staff to complete this form as I am unable due to ____ (Initial______) I will not hold my doctor or any members of his/her employment responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient Date

Signature Of Medical Assistant Date