NEUROLOGY ASSOCIATES OF SANTA BARBARA

PHONE 805.682.8153 FAX 805.682.5585

HEALTH HISTORY FORM

PATIENT NAME: _____ **DOB:** _____ **AGE:** _____

Referring Doctor: _____ **Primary Care Physician:** _____

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY. THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.

PLEASE DESCRIBE THE REASON FOR SEEING THE DOCTOR TODAY: _____

_____

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_____

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PLEASE ENTER: HEIGHT: _____FT_____IN **WEIGHT:** ____LBS **DOMINANT HAND:** ❑ RIGHT ❑ LEFT ❑ BOTH

1. **PAST MEDICAL HISTORY:** – Have you ever had the following: ❑ **Patient denies any Past Medical History**

❑ Asthma	❑ Diabetes	❑ Hepatitis	❑ Seizures
❑ Bladder Disorders	❑ Gait Problems	❑ High Blood Pressure	❑ Stroke
❑ Cancer	❑ Glaucoma	❑ Kidney Disease	❑ Thyroid Disease
❑ Depression	❑ Heart Disease	❑ Memory Problems	❑ Other _____

2. **PAST SURGICAL HISTORY:** – Have you ever had the following: ❑ **Patient denies any surgeries**

Please list all serious illnesses, operations & other hospitalizations you have experienced

❑ Colon Biopsy ❑ Hysterectomy ❑ Renal Biopsy

❑ Abdominal Surgery ❑ Back Surgery ❑ Gallbladder

❑ Appendectomy ❑ C-Section ❑ Other Surgery _____

3. **MEDICATIONS:** Please list **all medicines** you are currently taking ❑ please continue on back of sheet

❑ **I am not taking any prescription medications**

CURRENT MEDICATIONS	DOSAGE (mg)	HOW OFTEN PER DAY?

4. Please list all **DRUG ALLERGIES** ❑ **I deny any Allergies**

5. **FAMILY HISTORY:** Has any blood **relative** had any of the following: (Check box or leave blank if uncertain)

❑ **I deny family history**

	Relationship		Relationship
❑ Any Cancer		❑ Movement Disorder	
❑ Dementia		❑ Seizure	
❑ Headache/Migraine		❑ Stroke	
❑ Heart Disease		❑ Tremor	

6. SOCIAL HISTORY:

Tobacco: ❑ never ❑ minimal ❑ yes (___packs/day x ___ yrs.) ❑ Quit ___yrs. ago (___packs/day x ___ yrs.)

Alcohol: ❑ never ❑ minimal ❑ less than 10 per week ❑ more than 10 per week

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Education level: ❑ High School ❑ College ❑ Post Graduate ❑ Other

Occupation: _____ **Retired:** _____

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7. REVIEW OF SYSTEMS:

DO YOU HAVE NOW OR HAVE YOU HAD ANY OF THE BELOW PROBLEMS WITHIN THE PAST YEAR:

(Please mark anything you have a history of)

Constitutional: ❑ fever, ❑ chills, ❑ fatigue, ❑ weight change, ❑ poor appetite,

Eyes: ❑ change in vision ❑ impaired vision,

HENT: ❑ sore throat ❑ hearing loss

Breast: ❑ lumps ❑ tenderness

Cardiovascular: ❑ chest pain ❑ irregular heartbeats ❑ rapid heartbeat ❑ ankle swelling

Respiratory: ❑ coughing ❑ shortness of breath ❑ sleep apnea ❑ wheezing

Gastrointestinal: ❑ heartburn ❑ loss of appetite ❑ nausea ❑ vomiting

Genitourinary: ❑ urgency ❑ frequency ❑ incontinence

Skin: ❑ rash ❑ itching

Neurological: ❑ tingling or numbness ❑ incoordination ❑ history of stroke ❑ memory difficulties, ❑ seizures ❑ tremor ❑ migraine

Musculoskeletal: ❑ back pain ❑ joint pain ❑ muscle pain,

Endocrine: ❑ excessive thirst ❑ loss of hair ❑ change in libido ❑ hot flashes

Psychiatric: ❑ anxiety ❑ depression ❑ mood swings

Heme-Lymph: ❑ easy bleeding ❑ lymph node enlargement or tenderness,

Allergic- Immunologic: ❑ sinus allergy symptoms ❑ allergic rash

Please Add Any Other Relevant Information Here:

_____

_____

_____

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_____ _____

Signature of patient/guardian **Date**