



Jefferson Neurology LLC

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HEALTH HISTORY

Please print in the information below to the best of your ability

Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Which hand do you write with: Right _____ Left _____

Primary Physician: _____ Referring Physician: _____

Other Physicians: _____

Pharmacy (Name and Location): _____

Medicare Patients: Do you have an Advance Directive? _____ Yes _____ No

Briefly, state the problem you have been referred for:

Past Medical History: (Check any of the following that you are presently or in the past have been under treatment for):

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Cancer (list type or area effected) |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> All other illnesses: |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Kidney Disease/Failure | _____ |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Bladder Problems | _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Stroke (Include Mini-Stroke) | <input type="checkbox"/> Emphysema | _____ |

SURGERY: (List type of surgery and date/year)

MEDICATIONS: (PLEASE INCLUDE DOSE AND HOW OFTEN YOU TAKE THE MEDICATION)	ALLERGIES:

FAMILY: (Give age and present health and list medical problems. If deceased give age and cause of death.)

Mother: _____ Father: _____

Sisters: _____ Brothers: _____

Others: (Major or hereditary conditions in grandparents, aunts, uncles or cousins) _____

SOCIAL: Marital Status: _____ # in Household: _____ Occupation: _____

Tobacco: Current Quit Never. Number of cigarettes/packs a day: _____ Years smoked: _____

Years Quit: _____ Alcohol use: _____ Drugs: _____ Level of education: _____

Review Of Systems: Please circle any personal history below:

Constitutional Symptoms

Good general health lately No Yes
 Recent weight change No Yes
 Fever No Yes
 Fatigue No Yes

Eyes

Eye disease or injury No Yes
 Wear Glasses/contact lenses. No Yes
 Blurred or double vision No Yes

Ears/se/Mouth/Throat

Hearing loss or ringing No Yes
 Earaches or drainage No Yes
 Chronic sinus problem or rhinitis No Yes
 Nose bleeds No Yes
 Mouth Sores No Yes
 Bleeding gums No Yes
 Bad breath or bad taste No Yes
 Sore throat or voice change No Yes
 Swollen glands in neck No Yes

Cardiovascular

Heart trouble No Yes
 Chest pain or angina pectoris No Yes
 Palpitation No Yes
 Shortness of breath w/walking
 or lying flat No Yes
 Swelling of feet, ankles or hands No Yes

Respiratory

Chronic or frequent coughs No Yes
 Spitting up blood No Yes
 Shortness of breath No Yes
 Wheezing No Yes

Gastrointestinal

Loss of appetite. No Yes
 Change in bowel movements No Yes
 Nausea or vomiting No Yes
 Frequent diarrhea No Yes
 Painful bowel movements
 or constipation No Yes
 Rectal bleeding or blood in stool No Yes
 Abdominal pain No Yes

Genitourinary

Frequent Urination No Yes
 Burning or painful urination No Yes
 Blood in urine No Yes
 Change in force of stream
 When urinating No Yes
 Incontinence or dribbling No Yes
 Kidney stones No Yes
 Sexual difficulty No Yes
 Male-testicle pain No Yes
 Female-Pain with periods No Yes
 Female - irregular periods No Yes
 Female - vaginal discharge No Yes
 Female-# of pregnancies _____
 Female - # of miscarriages _____
 Female - date of last Pap _____

Musculoskeletal

Joint pain No Yes
 Joint stiffness or swelling No Yes
 Weakness of muscle or joints No Yes
 Muscle pain or cramps No Yes
 Back pain No Yes
 Cold extremities No Yes
 Difficulty in walking No Yes

Integumentary (Skin, Breast)

Rash or itching No Yes
 Change in skin color No Yes
 Change in hair or nails No Yes
 Varicose veins No Yes
 Breast pain No Yes
 Breast lumps No Yes
 Breast discharge No Yes

Neurological

Frequent or recurring headaches No Yes
 Lightheaded or dizzy No Yes
 Convulsions or seizures No Yes
 Numbness or tingling sensations No Yes
 Tremors No Yes
 Paralysis No Yes
 Head injury No Yes

Psychiatric

Memory loss or confusion No Yes
 Nervousness No Yes
 Depression No Yes
 Insomnia No Yes

Endocrine

Glandular or hormone problem No Yes
 Excessive thirst or urination No Yes
 Heat or cold intolerance No Yes
 Skin becoming drier No Yes
 Change in hat or glove size No Yes

Hematologic/Lymphatic

Slow to heal after cuts No Yes
 Bleeding or bruising tendency No Yes
 Anemia No Yes
 Phlebitis No Yes
 Past transfusion No Yes
 Enlarged glands No Yes

Allergic/Immunologic

History of skin reaction or other
 adverse reaction to:
 Penicillin or other antibiotics No Yes
 Morphine, Demerol, or other
 narcotics No Yes
 Novocain or other anesthetics No Yes
 Aspirin or other pain remedies No Yes
 Tetanus antitoxin
 or other serums No Yes
 Iodine No Yes

Other drugs/medications: _____

Known Food/Environmental allergies

Doctor's Review (Please do not write in this area)

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any change in my medical status. I also authorize the healthcare staff to perform the services I may need. I have reviewed, agree and consent to the sections relating to policies, consent and authorization in the document provided to me: New Patient Information (Ver 1.4).

 Patient's Name

 Signature

 Date