

*Please complete this form and bring with you to your appointment*  
**DEPARTMENT OF NEUROLOGY - MEDICAL FACULTY ASSOCIATES**

**CLINICAL HISTORY FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Please circle: **MALE** **FEMALE**

Referring Doctor of Primary Care Physician: \_\_\_\_\_

Referring Doctor's Address: \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Where is the location of the problem? \_\_\_\_\_ When do symptoms occur? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

How long have you had these symptoms? \_\_\_\_\_ Are the symptoms related to an injury? **NO** **YES**

Was the injury work related? **NO** **YES**, Date of injury: \_\_\_\_\_ Job Title or duties: \_\_\_\_\_

Are you presently working? **NO** **YES** Date last worked: \_\_\_\_\_ Work Capacity: **FULL** **PART**

**Review of Systems: (Please check all that apply)**

<p><b>Constitutional</b></p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Weight loss</p> <p><b>Cardiovascular</b></p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Irregular heartbeat</p> <p><b>Respiratory</b></p> <p><input type="checkbox"/> Chronic cough/coughing blood</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Asthma</p> <p><b>Gastrointestinal</b></p> <p><input type="checkbox"/> Blood in Stool/Dark stool</p> <p><input type="checkbox"/> Nausea/Vomiting</p> <p><input type="checkbox"/> Abdominal pain</p> <p><b>Psychological</b></p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Anxiety</p>	<p><b>Genitourinary</b></p> <p><input type="checkbox"/> Burning with urination</p> <p><input type="checkbox"/> Difficulty starting/ending urine stream</p> <p><input type="checkbox"/> Poor bladder control of incontinence</p> <p><input type="checkbox"/> Sexual dysfunction</p> <p><input type="checkbox"/> Loss of sensation of genitals</p> <p><input type="checkbox"/> Inability to obtain, maintain erection</p> <p><b>Endocrine</b></p> <p><input type="checkbox"/> Nipple discharge</p> <p><input type="checkbox"/> Dry skin</p> <p><input type="checkbox"/> Loss or gain of body hair</p> <p><input type="checkbox"/> Weight loss or weight gain</p> <p><input type="checkbox"/> Excessive thirst</p> <p><b>Hematology</b></p> <p><input type="checkbox"/> Easy bruising</p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Excessive bleeding with previous surgeries</p>	<p><b>Neurological</b></p> <p><input type="checkbox"/> Change of vision (blurry, double)</p> <p><input type="checkbox"/> Loss of hearing of ringing in ears</p> <p><input type="checkbox"/> Facial numbness</p> <p><input type="checkbox"/> Facial weakness</p> <p><input type="checkbox"/> Decrease sense of smell or taste</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Slurred speech</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Pain in the arm _____</p> <p><input type="checkbox"/> Pain in the leg _____</p> <p><input type="checkbox"/> Numbness of the arm</p> <p><input type="checkbox"/> Numbness of the leg</p> <p><input type="checkbox"/> Weakness in the leg</p> <p><b>Musculoskeletal</b></p> <p><input type="checkbox"/> Neck pain</p> <p><input type="checkbox"/> Loss of arm/leg coordination</p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Trouble walking</p>
---	---	--

**Past Medical History**

<p><input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> Hear Disease</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Other</p>	<p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Kidney problems</p> <p><input type="checkbox"/> Liver disease</p>	<p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> HIV</p> <p><input type="checkbox"/> Asthma of lung disease</p>
---	--	---

**Past History of Surgery or Hospitalization**

Date	Type of surgery or illness	Reason for Surgery or Hospitalization

Other information:

---



---



---



---

LABEL

**Family History: Please list any medical problems that run in your family.**

Father – age: \_\_\_\_\_ (alive/deceased): \_\_\_\_\_

Mother – age: \_\_\_\_\_ (alive/deceased): \_\_\_\_\_

Siblings – age: \_\_\_\_\_ (alive/deceased): \_\_\_\_\_

Siblings – age: \_\_\_\_\_ (alive/deceased): \_\_\_\_\_

Siblings – age: \_\_\_\_\_ (alive/deceased): \_\_\_\_\_

**Social History:**

Marital status:  SINGLE  MARRIED  DIVORCED  WIDOWER

Education:  GRADE SCHOOL  MIDDLE SCHOOL  HIGH SCHOOL  GED  COLLEGE

Do you exercise? NO YES How often per week? \_\_\_\_\_

Do you currently smoke? NO YES How much per day and for how many years? \_\_\_\_\_

Do you drink alcohol? NO YES Number of drinks per week? \_\_\_\_\_

Do you use illicit drugs? NO YES How much dollar amount used on drugs per week? \_\_\_\_\_

Are you on any special diet? \_\_\_\_\_

**Allergies to Medication: List drug names and reaction to each drug.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**List Current Medications (attach a list if necessary)**

Name of Medication	Dosage (milligrams)	Number of tablets taken in one day

PHARMACY – Name, Address, Contact Information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**My signature signifies that I have read, answered, and truthfully understand the information included in this form as part of my medical evaluation.**

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Reviewed by MD Date

LABEL