Collier Neurologic Confidential Health History

Name_____ Birth Date_____ Today's date_____
Age_____ Primary Physician_____ Reason for Visit_____
Pharmacy Name and address_____

Review of Systems As Required by Medicare and Private insurers.

Have you had any of these symptoms recently

Please circle yes or no for each topic

Constitutional
Y N Weight change
Y N Fever
Y N Night sweats
Y N Feeling Tired

Eyes
Y N Worsening Acuity
Y N Seeing Double
Y N Eye Pain
Y N Other eye symptoms

Gut Symptoms
Y N Constipation
Y N Heartburn
Y N Nausea
Y N Vomiting
Y N Abdominal Pain
Y N Diarrhea
Y N Soiling Underwear
Y N Blood in stool
Y N Other gut symptoms

Ears, Nose Mouth, Throat
Y N One side loss of hearing
Y N Both side loss of hearing
Y N Ringing in ears
Y N Throat Pain
Y N Mouth Pain
Y N Nosebleeds

Lungs
Y N Cough
Y N Coughing up blood
Y N Night sweats
Y N Wheezing
Y N Coughing up Sputum
Y N Shortness of Breath
Y N Other lung symptoms

Urinary
Y N Blood in Urine
Y N Pain on urination
Y N Increased urinary frequency
Y N Loss of control (wet self)
Y N other urinary issues

Blood
Y N Easy bleeding
Y N Easy bruising
Y N Swollen glands neck
Y N Swollen glands armpits

Heart
Y N Chest Pain
Y N Fast heart rate
Y N Palpitations

Skin
Y N Itch- uncontrollable
Y N Skin sores
Y N Rash
Y N Other skin symptoms

Endocrine
Y N Excessive Sweating
Y N Excessive thirst
Y N Diminish heat tolerance
Y N Diminish cold tolerance

Allergy
Y N Watery Nasal discharge
Y N Seasonal allergies
Y N Contact allergies
Y N food allergies

Neurological
Y N Dizziness
Y N Weakness
Y N Numbness
Y N Headache
Y N Falls

Mood
Y N Poor sleep
Y N Diminished pleasure in doing things
Y N feeling down/ depressed/ hopeless
Y N change in personality
Y N Sense of impending Doom
Y N Impulsive behavior

Musculoskeletal Pain
Y N Shoulder
Y N Arm
Y N Hand
Y N Fingers
Y N Hip
Y N Leg
Y N Foot

Please Turn Page Over and Complete Back Side

List all past medical problems and surgeries you have had

_____
_____
_____
_____

List all medications and their doses you take, Please include over the counter drugs and herbals. _____
_____
_____
_____

Drug Allergies: _____
_____

Please list recent (in last 6 months) blood, cardiac, and radiologic testing and where it was done _____

Social History

Number of children_____ Are you: Married_____ Divorced_____ Widowed_____ Other___
Highest diploma obtained_____ Do you or did you smoke_____ When did you Quit____
Packs per day smoked_____ Number of years smoked_____
Do you drink any type of alcohol_____ What type (beer, wine , hard liquor)_____
How many days per week___ ____
How many drinks per day_____How many ounces in each drink?_____
Have you used Marijuana, cocaine,injectable drugs_____ Last time used_____

Family History

	Alive Y/N	Age at death	Cause of death
Mother			
Father			
Sister			
Sister			
Brother			
Brother			
Child			
Child			

Patient's Signature _____