NEUROVATIONS CLINIC

PATIENT HISTORY FORM

Referred by: ☐ Friend ☐ Family ☐ Physician: _____ ☐ Online: _____

Patient Name: _____ DOB: _____ Date: _____

Check circle any of the following diagnosis if had or do have:

Eyes:
Pain
redness
loss of vision
watery eyes
Discharge from eyes
Light Sensitivity
Double Vision

Ear/Nose/Throat:
Ear Pain
Ear discharge
ringing in the ears
Hearing Loss
Nasal Congestion
Nose Bleeds
Sore Throat
Hoarseness
Swallowing trouble/pain

Genitourinary:
Blood in urine
Penile discharge
Frequent urinations at night
Incontinence
Decreased sex drive
Erectile dysfunctions
Testicular mass or tenderness
Painful urination

Musculoskeletal:
Joint Pain
Joint Swelling
Muscle cramps
Muscle aches
Muscle weakness
Numbness in the pelvis
Muscular Disease

Skin:
Rash
itching
Dry Skin
Changing/Suspicious spots
Non-healing sores
Bruising

Neurologic:
Seizures
Tremors
Frequent headaches
Tingling
Balance
Numbness
Incontinence
Numbness in the pelvic region
Headaches/Migraine
Vertigo
Nerve Pain
Aneurysm
Dizziness
Stroke
TICS
Speech difficulty
Head injury
Facial droop

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Confusion
Slurred speech

Mental Health:

Sleep disturbance
Mood swings
Depressed mood
Confusion
Suicidal thoughts
Memory Loss
Increased Irritability
Anxiety /Panic Attacks
Difficulty concentrating
Hallucinations,
Excessive energy
Decreased energy

Hematologic:

Bleeding
Easy bruising
Enlarged lymph node
weight loss/gain
on anticoagulants (blood thinners)

Allergic/immunologic:

Hay fever
Seasonal allergies
Hives
Frequent infections
Frequent Sneezing
itchy eyes
Eczema
Latex sensitivity
Hx of immune deficiency

Family History:

Dementia
Ataxia
Heredity neuropathy
Muscular Dystrophy
Epilepsy
Aneurysm
Huntington/or Parkinson's
Neurofibromatosis/ tuberous sclerosis
Mitochondrial or Autonomic clots

Diabetes Mellitus: _____

Medical Rec: Herbal Preparations (yes/no)? _____

Circle if you have any of the following:

Mitral valve prolapsed
Joint replacement
Pacemaker/defibrillator

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Organ transplant Heart defect Artificial heart valve
Heart murmur

Other medical history: _____

List all medications you are currently taking, including over the counter medications:

Medication	**Strength**	**How Often**	**Medication**	**Strength**	**How Often**

List your allergies (severity/outcomes) _____
Social History: Do you smoke (if so, how much/day)? _____ Do you drink alcohol (if so, how much/day)? _____ Do you use recreational drugs (if so, what and how often)?_____
Have you ever been exposed to HIV/Syphilis (AIDS)?
_____
Surgeries? _____