NEUROVATIONS CLINIC

PATIENT HISTORY FORM

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

Patient Name: _____ DOB: _____ Date: _____

Height: _____ Weight: _____

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

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

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

Neurologic:
Weakness
Seizures
Tremors
Headaches/migraine
Tingling
Numbness
Incontinence
Numbness in the pelvic region
Vertigo
Nerve Pain
Aneurysm

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Mental Health:

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

Hematologic:

Bleeding
Easy bruising
Enlarged lymph node
weight loss/gain

Allergic/immunologic:

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

Family Medical History: _____

Diabetes Mellitus: (yes/no)? _____

List Your Past 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 What, how often**? _____ Have **you ever been exposed to HIV/Syphilis (AIDS) (yes/no)? _____**

List any Surgeries?

_____