ROCKY MOUNTAIN NEUROLOGICAL ASSOCIATES

Name:______________________

HISTORY OF PRESENT ILLNESS

Describe briefly your present symptoms: ______________________

Date symptoms began ______________ Diagnosis given? ______________

List other physicians you have seen for this problem: ______________________

Previous treatment for this problem (include physical therapy, surgery and injections).

Current Medications: ______________________

PAST PERSONAL HISTORY

Do you or have you had: (check if "yes")

Cancer ________ Heart Problems ________ Asthma ________ Thyroid ________

Leukemia ________ Stroke ________ Cataracts ________ Diabetes ________

Epilepsy ________ Nervous breakdown ________ Stomach ulcers ________ Rheumatic Fever ________

Headaches ________ Jaundice ________ Colitis ________ Kidney Disease ________

Pneumonia ________ Psoriasis ________ Anemia ________ Multiple Sclerosis ________

Other significant illness (Please list) ______________________

Previous Operations:

	Type	Year	Surgeon	City
1)				
2)				
3)				
4)				
5)				

Any serious injuries? Yes _____ No _____ Describe ______________________

FAMILY HISTORY

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of Brothers _____ Number Living _____ Number of Sisters _____ Number Living _____

Number of Children _____ Number Living _____ List ages of each ______________

Serious illneses of your siblings and children ______________________

Do you know of any blood relative who has or had: (check and give relationship)

Cancer ________ Heart disease ________ Thyroid ________

Leukemia ________ High Blood Pressure ________ Epilepsy ________

Stroke ________ Bleeding tendency ________ Migraine ________

Diabetes ________ Alcoholism ________ Multiple Sclerosis ________

Other significant illnesses in family member ______________________

(OVER)

ROCKY MOUNTAIN NEUROLOGICAL ASSOCIATES

Name:______________________________

Date of Birth:__________ Today's Date:__________

SYSTEMS REVIEW

As you review the following list, **please check any of those problems which apply to you.**

GENERAL:
____Recent weight gain/Amount
____Recent loss of weight/Amount
____Fatigue
____Weakness
____Fever

NERVOUS SYSTEM:
____Headaches
____Dizziness
____Fainting
____Muscle spasm
____Loss of consciousness
____Numbness of hands and/or feet
____Memory Loss

EARS:
____Ringing in ears
____Recent Loss of hearing

EYES:
____Pain
____Redness
____Loss of vision
____Double vision
____Blurred vision
____Dryness

NOSE:
____Loss of smell

MOUTH:
____Sores in mouth
____Loss of taste
____Dryness

THROAT:
____Hoarseness
____Difficulty in swallowing

HEART AND LUNGS:
____Pain in chest
____Irregular heart beat
____Sudden changes in heart beat
____Shortness of breath
____Difficulty in breathing at night
____Swollen legs or feet
____High blood pressure
____Wheezing
____Night sweats

STOMACH AND INTESTINES:
____Nausea
____Increasing constipation
____Persistent diarrhea
____Blood in stools
____Black stools
____Heartburn

KIDNEY/URINE/BLADDER:
____Difficult urination
____Frequent urination
____Getting up at night to pass urine
____Sexual difficulties
____Prostate trouble

BLOOD:
____Anemia
____Bleeding tendency

SKIN:
____Easy bruising
____Rash
____Hives
____Sun sensitive
____Nodules/bumps
____Hair loss
____Color changes of hands or feet in the cold

MUSCLES/JOINTS/BONES:
____Joint pain
____Muscle weakness
____Muscle tenderness

HABITS:
Do you drink alcoholic beverages?
Yes____ No ____ If yes, how many per day? _____ per week? _____
Do you smoke? Yes____No ____Past____
Cigarettes per day? ______________
Do you use drugs for reasons that are not medical? If so, please list:
____
____
Do you get enough sleep at night?
Yes _____ No _____

Right handed _____ Left handed _____

Daytime Activities:
Employed ? Yes______ No______ Job Title ______________________________
Retired? _______ If so, when? ________
Other typical daily activities if not employed: ______________________________
____
____

(OVER)