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Board Certified Neurology

NAME:_____DATE OF BIRTH:_____
MARITAL STATUS: S M W D NUMBER OF CHILDREN:_____
WEIGHT:_____HEIGHT:_____ ARE YOU DIABETIC:_____
ALLERGIES TO MEDICATIONS:_____
MEDICATIONS YOU ARE NOW TAKING: (Names and dosage):_____
_____
_____

ANY HISTORY OF:	YES	NO		YES	NO
HEAD INJURY	____	____	HEART DISEASE	____	____
EPILEPSY	____	____	LUNG DISEASE	____	____
ANEURYSM	____	____	SKIN DISEASE	____	____
STROKE	____	____	KIDNEY DISEASE	____	____
BLACKOUTS	____	____	LIVER DISEASE	____	____
HEADACHES	____	____	INTESTINAL DISEASE	____	____
DIZZINESS	____	____	ARTHRITIS	____	____
PACEMAKER	____	____	BACK PROBLEMS	____	____
DEAFNESS	____	____	NECK PROBLEMS	____	____
RINGING IN EARS	____	____	FORGETFULNESS	____	____
BLURRED VISION	____	____	PERSONALITY CHANGE	____	____
DOUBLE VISION	____	____	SLEEPING DIFFICULITY	____	____
MUSCULAR WEAKNESS	____	____	DEPRESSION	____	____
ARM OR LEG NUMBNESS	____	____	BIRTH INJURY	____	____
ARM OR LEG PAIN	____	____	BRAIN SURGERY	____	____
WALKING DIFFICULTY	____	____	BACK SURGERY	____	____
BLADDER PROBLEMS	____	____	NECK SURGERY	____	____
BOWEL PROBLEMS	____	____	METAL IN YOUR BODY	____	____

Have you ever been diagnosed with an infectious disease? _____Yes _____ No
If yes, please provide date/s and diagnosis/diagnoses:_____
_____
List major operations and when preformed: _____
_____

Do you smoke?: _____ Do you drink alcoholic beverages?_____

How much?: _____ How much and how often? _____