PENINSULA
PRIVATE NEUROLOGY

Allergies	Reaction	Comments

Are you allergic to IV contrast or shell fish? (circle 'yes' or 'no') Yes No

Medications		
Medication Name	Dose	How often taken?

Medical History (circle 'yes' or 'no')								
Atrial Fibrillation	Yes	No	Hepatitis C	Yes	No	Parkinson's Disease	Yes	No
Aortic Stenosis	Yes	No	Stomach Ulcers	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Anemia	Yes	No	Nerve/Muscle Disease	Yes	No
Heart Failure	Yes	No	Deep Vein Thrombosis	Yes	No	Neurologic Disease	Yes	No
High Cholesterol	Yes	No	Leukemia	Yes	No	Alcohol Problem	Yes	No
High Blood Pressure	Yes	No	Pulmonary Embolism	Yes	No	Depression	Yes	No
Myocardial Infraction	Yes	No	Infection with MRSA (Methacillin Resistant Staph)	Yes	No	Asthma	Yes	No
Blood Clotting Disorder	Yes	No	Infection with VRE	Yes	No	Emphysema (COPD)	Yes	No
Heart Murmur	Yes	No	Dementia	Yes	No	Obstructive Sleep Apnea	Yes	No
Artificial Murmur Valve	Yes	No	Seizure Disorder	Yes	No	Tuberculosis	Yes	No
Blood Vessel Blockage (arm or leg)	Yes	No	Brain Tumor	Yes	No	End-Stage Renal Disease (Kidney Failure)	Yes	No
Diabetes	Yes	No	Head Injury	Yes	No	Urinary Insufficiency	Yes	No
Thyroid Disease	Yes	No	Migraine h/a	Yes	No	Obesity	Yes	No
Cancer	Yes	No				Drug Abuse	Yes	No
Immune Disorder	Yes	No				Sexually Transmitted Disease	Yes	No

Other Medical History

Surgical History (circle 'yes' or 'no')					
Appendectomy	Yes	No	Coronary Bypass Graft	Yes	No
Cardiac Catherterization	Yes	No	Hysterectomy	Yes	No
Hernia Repair	Yes	No	Tonsil and Adnoidectomy	Yes	No
Carotid Artery Surgery	Yes	No	Heart Surgery / Angioplasty	Yes	No

Other Surgical History

Tobacco Use
Yes ☐ No ☐ Quit Date:
Packs per Day
For how many years?

Alcohol Use	
Yes ☐ No ☐	
Number of Drinks per week:	☐ Can(s) of beer each week
	☐ Shot(s) of alcohol each week
	☐ Drink(s) containing 0.5 oz. of alcohol each week

Exercise			
Yes No			
If yes, how much?	Rarely ☐	Occasionally ☐	More than 3 times per week ☐

Family Health History	**Living? (L) Deceased? (D) Unknown? (U)**	**Medical Conditions**
Mother		
Father		
Mother's Mom		
Mother's Dad		
Father's Mom		
Father's Dad		
Brother		
Sister		
Other		

Review of Systems **Do you presently have any problems or symptoms in the following areas?** (check 'yes' or 'no')				
System	No	Yes	Comments	Physician Comments
ALLERGIC / IMMUNOLOGIC				
Low resistance to infection				
Environmental allergies				
CARDIOVASCULAR				
Chest Pain or Angina				
Irregular heart rhythm				
CONSTITUTIONAL				
Recent weight change				
Good general health lately				
Recurrent fevers, chills, sweats				
Extreme fatigue				
Frequent nausea, vomiting				
Difficulty sleeping				
EAR, NOSE, AND THROAT				
Change in hearing				
Ringing in the ears				
Recent nose bleeds				
Chronic sinus problems				
Voice changes				
EYES				
Change in vision				
Glaucoma				
GASTROINTESTINAL				
Change in appetite				
Severe heartburn				
Vomiting blood				
Constipation				
Black or bloody stools				
Abdominal pain				
GENITOURINARY				
Blood in urine				
Burning with urination				
Difficult/frequent urination				
Lack of bladder control				
Sexually transmitted disease				
Change in sexual function				

Review of Systems (continued)
Do you presently have any problems or symptoms in the following areas? (check 'yes' or 'no')

System	No	Yes	Comments	Physician Comments
HEMATOLOGIC / LYMPHATIC				
Easy bruising				
Frequent bleeding				
Enlarged lymph nodes				
INTEGUMENTARY				
Unusual or prolonged rashes				
Breast pain or lump				
Change in hair or nails				
MUSCULOSKELETAL				
Joint swelling				
Difficulty swallowing				
NEUROLOGIC				
Headaches				
Numbness/tingling sensation				
Weakness or paralysis				
Convulsions or seizures				
Change in memory/concentration				
Loss or blurring of vision, or double vision				
Black-out/dizziness				
Memory loss or confusion				
Other neurological problems				
PAIN				
Joint stiffness or pain				
Muscle pain				
Neck pain				
Back pain				
Other pain				
PSYCHIATRIC				
Nervousness				
Depression				
Other				
RESPIRATORY				
Breathing problems or shortness of breath				
Coughing up blood				
Chronic cough				