Neurology Health History Questionnaire:

FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative phone number_____

Please describe what problem or concern brought you to our office today:

_____

Details of Chief Complaint:									
How long has this been going on?									
Please rate your pain, circle one:	1	2	3	4	5	6	7	8	9	10
Is the problem on the Right Side? ☐ Y ☐ N				Is the problem on the Left Side? ☐ Y ☐ N						
What makes the symptoms better?										
What makes the symptoms worse?										
What test(s) have you had recently in relation to your problem?										

Personal Health History		Previous Surgical Procedures	
Please check past(P) or current(C) problems or conditions		Procedure	Year
P☐ C☐ Hypertension	P☐ C☐ Osteoporosis/ Osteopenia	☐ Heart surgery	
P☐ C☐ High cholesterol		☐ Carotid artery surgery	
P☐ C☐ Diabetes	P☐ C☐ Bowel/digestive problem	☐ Vascular surgery / stent	
P☐ C☐ Heart attack or angina	P☐ C☐ Seizures	☐ Abdominal aneurysm repair	
P☐ C☐ Irregular heart rhythm	P☐ C☐ Headaches	☐ Intestinal surgery	
P☐ C☐ Congestive heart failure	P☐ C☐ Stroke	☐ Hysterectomy Ovaries Rem.? ☐ Y ☐ N	
P☐ C☐ Asthma	P☐ C☐ Prostate problem	☐ Pacemaker	
P☐ C☐ Emphysema or chronic bronchitis	P☐ C☐ Breast problem	☐ Gallbladder removed	
	P☐ C☐ Urinary tract infections	☐ Appendix removed	
P☐ C☐ Pneumonia	P☐ C☐ Arthritis	☐ Joint replacement ☐ Hip ☐ Right ☐ Left ☐ Knee ☐ Right ☐ Left	
P☐ C☐ Gastroesophageal reflux disease	P☐ C☐ Thyroid problem		
	P☐ C☐ Bleeding disorder		
P☐ C☐ Atrial Fibrillation	P☐ C☐ Addiction Issues	☐ Spine Surgery ☐ Neck ☐ Back	
P☐ C☐ Kidney Disease, Type:	P☐ C☐ Depression or anxiety	☐ Breast cancer surgery	
P☐ C☐ Liver Disease, Type:	P☐ C☐ Mental Illness	☐ Prostate cancer surgery	
P☐ C☐ Cancer, Type:	P☐ C☐ Other:	☐ Hernia	
P☐ C☐ Stomach ulcer		☐ Other: _____	

Social History:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Live here year round? ☐ Yes ☐ No If no, Part time location: _____

Occupation: **Concerns**: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting

Tobacco use: ☐ Never ☐ Quit (when)_____ ☐ Current smoker: Packs/day, how many years_____

Alcohol use: ☐ No ☐ Yes If yes how many drinks/how often_____

Caffeine use: ☐ No ☐ Yes If yes, ☐ Coffee ☐ Soda ☐ Tea how many drinks/how often_____

Illicit Drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current
Describe:_____

Current Health Concerns			
Please check problems or conditions that you are CURRENTLY experiencing			
☐ Chest pain	☐ Rectal bleeding	☐ Eye pain	☐ Nervousness
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Pain in testicles
☐ Wheezing	☐ Weight loss	☐ Double vision	☐ Loss of libido
☐ Cough	☐ Weight gain	☐ Memory loss	☐ Impotence
☐ Coughing up blood	☐ Loss of appetite	☐ Ringing in ears	☐ Breast pain
☐ Sore throat	☐ Difficulty swallowing	☐ Pain in ears	☐ Breast discharge
☐ Nasal congestion	☐ Diarrhea	☐ Nose bleeds	☐ Other (please describe below)
☐ Irregular heartbeat	☐ Constipation	☐ Hoarseness	
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	
☐ Low blood pressure	☐ Urine frequency	☐ Rash	
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	**Females - Please complete**
☐ Dizziness/fainting	☐ Urine leakage	☐ Sore that won't heal	Menstrual flow:
☐ Abdominal pain	☐ Headaches, frequent	☐ Fatigue/lethargy	☐ Reg. ☐ Irreg. ☐ Pain/cramps
☐ Heartburn	☐ Hemorrhoids	☐ Insomnia	Days of flow __ Length of cycle__
☐ Indigestion	☐ Loss of strength	☐ Forgetfulness	1st day of last period_____
☐ Ankle swelling	☐ Balance problems	☐ Depression	☐ Pain or bleeding after sex
☐ Nausea	Pain, weakness, or numbness in		Number of pregnancies _____
☐ Vomiting	☐ Arms ☐ Hips	☐ Back	Miscarriages_____
☐ Vomiting blood	☐ Legs ☐ Neck	☐ Shoulders	Birth control method _____
☐ Change in bowel habits	☐ Hands ☐ Feet	☐ Abdomen	Menopause ☐ Y ☐ N Age: _____

Family History			
Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically, have any of your relatives had the following conditions:				
Condition	Relative		Condition	Relative
☐ Mental illness			☐ Chemical dependency	
☐ Diabetes			☐ Stroke	
☐ Thyroid Disease			☐ Arthritis	
☐ Pituitary Disease			☐ Dementia	
☐ Chrohn's/Colitis			☐ Hypertension	
☐ Cancer, Type: _____			☐ Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Health Maintenance:

Please check whether you have had the following preventive services and enter the year of the service

Immunizations			Last Occurrence	Tests			Last Occurrence
Tetanus vaccine / Tdap	☐ Yes	☐ No		Mammogram	☐ Yes	☐ No	
Pneumonia vaccine	☐ Yes	☐ No		Ultrasound	☐ Yes	☐ No	
Influenza vaccine	☐ Yes	☐ No		CT Scan	☐ Yes	☐ No	
Shingles vaccine	☐ Yes	☐ No		MRI	☐ Yes	☐ No	
Hepatitis ☐ A ☐ B	☐ Yes	☐ No		PET Scan	☐ Yes	☐ No	
Guardasil (HPV)	☐ Yes	☐ No		Colonoscopy	☐ Yes	☐ No	
				Chest X-Ray	☐ Yes	☐ No	
				Pap smear/pelvic	☐ Yes	☐ No	
				Bone Density	☐ Yes	☐ No	
				Prostate test	☐ Yes	☐ No	

Hospital Admissions (excluding pregnancies):

Date	Hospital	Reason for admission

Allergies:

Please list any allergies to medications or foods

Name	Symptom/Reaction

Medications:

Please list any medications that you take including over the counter medications, herbs, and supplements.

Name	Dose	Freq.	Name	Dose	Freq.

Pharmacy: _____ **Phone**: _____ **Store #**: _____

Location Description: _____

Specialty Providers:	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice	
Primary Care Name: _____ Phone: _____ Last Seen:_____	**Nephrologist** Name: _____ Phone: _____ Last Seen: _____
Cardiologist Name: _____ Phone: _____ Last Seen:_____	**Gynecologist** Name: _____ Phone: _____ Last Seen: _____
Oncologist Name: _____ Phone: _____ Last Seen:_____	**Allergist** Name: _____ Phone: _____ Last Seen: _____
Urologist Name: _____ Phone: _____ Last Seen:_____	**Psychiatrist/Psychologist** Name: _____ Phone: _____ Last Seen: _____
Gastroenterologist Name: _____ Phone: _____ Last Seen:_____	**Pulmonologist** Name: _____ Phone: _____ Last Seen: _____
Endocrinologist Name: _____ Phone: _____ Last Seen:_____	**Podiatrist:** _____ Name: _____ Phone: _____ Last Seen: _____
Ophthalmologist Name: _____ Phone: _____ Last Seen:_____	**Other:** _____ Name: _____ Phone: _____ Last Seen: _____

Patient/Guardian Signature:_____ Date:_____