PERSONAL HISTORY FORM, page 1 of 2

Please complete both sides

Patient Name ____Date ____________

Referred by_________________________ Family doctor_____________________________

Date of Birth ____________ Height ________ Wt. _________ Right Left handed (circle one)

Medical problem I'm seeing a Neurologist / Sleep specialist for:_______________________

____

Is this Work Related? _____ YES _____ NO

Past Medical History (check those that apply): __ Heart attack __High Blood Pressure__High Cholesterol
__Migraines/Sinus Headaches __Ulcer __GERD/Reflux __Coronary Artery Disease __Diabetes
__Thyroid Disease __Stroke __Seizures __Anxiety __Depression __Right/Left Cataract Surgery
__ Cancer __ Asthma __COPD/emphysema __ Arthritis __ anemia __Head Trauma

Other medical problems:____

____

Surgeries or hospitalizations:____

Review of systems: (circle those that apply to **YOU**):

1. CONSTITUTIONAL: fevers loss of appetite night sweats weight loss weight gain
2. EYES: blurry vision vision loss double vision redness eye pain
3. EAR, NOSE, THROAT: snoring hearing loss ringing in the ears earache sinus trouble
4. CARDIOVASCULAR: palpitations chest pain fainting legs swelling unable to lie flat
5. RESPIRATORY: cough shortness of breath hayfever
6. GASTROINTESTINAL: indigestion nausea vomiting
7. GENITAL / URINARY: frequent urination incontinence bedwetting nighttime urination urgency
8. NEUROLOGIC: sleepiness tremors headaches dizziness numbness
9. PSYCHIATRIC: restless sleep depression anxiety forgetfulness loss of consciousness
10. ALLERGY: hayfever sinus headaches hives
11. ENDOCRINE: irregular menses fatigue hot/cold intolerance
12. MUSCULOSKELETAL: neckpain back pain leg pain joint pain osteoporosis
13. HEMATOLOGIC: easy bleeding blood clots deep vein thrombosis pulmonary embolus blood transfusion
14. SLEEP: restless legs nocturnal choking leg cramps insomnia
15. ACTIVITIES OF DAILY LIVING: Are you experiencing any of the following?
    1. Difficulty with bathing, dressing or feeding yourself? No Yes
    2. Difficulty getting out of chairs or bed? No Yes
    3. Decreased movement or strength in your arms or legs? No Yes
    4. Have you fallen in the last month, or have balance problems? No Yes
    5. Has it been more than 5 years since you obtained a new wheelchair? No Yes
    6. Do you often choke on food, liquids or pills? No Yes
    7. Difficulty communicating your needs to others? No Yes
    8. Decrease in the loudness of your voice or ability to speak clearly? No Yes

Please complete both sides

Testing: Have you had any of these tests? (circle those that apply):

MRI Yes No If so, of what/where/when? ________________________________

CT Yes No If so, of what/where/when? ________________________________

EEG Yes No If so, where/when? ________________________________

EMG/Nerve Study Yes No If so, of what/where/when? ________________________________

Overnight Sleep Study Yes No If so, where/when? ________________________________

Other Yes No If so, what/where/when? ________________________________

Medications: (list both prescription & over the counter) _____ List attached

Medication name / strength	Times per day	Who prescribed

Medication allergies: ____ None:________

Social History: (circle those that apply)

Race: White African-American Asian Hispanic Other ________________

Occupation ____________________________ Retired unemployed Disabled Student Homemaker

Marital Status: Single Married Widowed Divorced Separated

I Live: Alone With Spouse With Partner With Children With Parents Own home Group home
Senior Apartment Assisted Living Nursing home

Smoker: No Yes _____ packs per day date quit ____________

Alcohol: No Yes _____drinks per week date quit ____________

Caffeinated Beverages: No Yes _____cups per day

Recreational Drugs: No Yes what kinds and how often? ________________________________

Exercise: No Yes Type and how often? ________________________________

Living Will: No Yes Full Resuscitation Do Not Resuscitate No Vent GenMedCare

Are you at risk for AIDS? No Yes

Family History: Do any of your immediate family members suffer from: (check those that apply)

__High Blood Pressure __Heart Disease __High Cholesterol __Cancer __Diabetes

__Thyroid Disease __Dementia __Parkinson's Disease __Muscle Weakness __Seizures

__Multiple Sclerosis __Attention Deficit __Alzheimer's __Migraine __Alcoholism

__Sleep Apnea __Restless Legs __Learning Disorders __Stroke

Mother: Living Age__________ Deceased Age __________

Father: Living Age__________ Deceased Age __________

Authorization to speak to a family member: No Yes Who? ________________________________

Reviewed by: ______________________________ Doctor's signature ________________________