PERSONAL HISTORY FORM, page 1 of 2
Please complete both sides

Unity health network
Neurology & Neuroscience

Patient Name ____ Date of Birth ___________

Referred by____

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

____

___A-fib __ Anemia __Anxiety __ Arthritis __ Asthma __Blood Clots __Cancer __COPD

__Coronary Artery Disease __Depression __Diabetes __DVT __Emphysema __Headaches __ Heart attack

__Hepatitis __Hernia __High Blood Pressure __High Cholesterol __HIV/AIDS __Hypersomnia

__Huntington's Disease __Migraines __Multiple Sclerosis __Narcolepsy __Neuropathy

__Pacemaker __Parkinson's Disease __Pulmonary Embolism __Reflux __Seizures __Stroke (date _______)

__TB __Thyroid Disease __Tremors __Trigeminal Neuralgia __Ulcer

__Sleep apnea (CPAP / BIPAP circle one) pressure _______ DME Co. ______________________________

Surgeries: (lifetime)____

____

____

Hospitalizations or ER visits in the last 6 months:____

____

Have you had any of the following tests in the past 5 years? (Check those that apply)
__CT __ EEG __ EMG/NCT __ Labs __ MRI

Review of Systems: (**circle** those that apply to **YOU in the LAST WEEK**):

CONSTITUTIONAL: Fevers Loss of Appetite Night Sweats Weight Loss Weight Gain

SLEEP: Restless Legs Choking at Night Leg Cramps Insomnia

ALLERGY: Hay Fever Sinus Headaches Hives

EYES: Blurry Vision Loss of Vision Double Vision

EAR, NOSE, THROAT: Snoring Hearing Loss Ringing in the Ears Sinus Problems

ENDOCRINE: Irregular Menses Fatigue Hot/Cold Intolerance

RESPIRATORY: Cough Shortness of Breath

CARDIOVASCULAR: Palpitations Chest Pain Fainting Legs Swelling

GASTROINTESTINAL: Indigestion Nausea Vomiting

HEMATOLOGIC: Easy Bleeding Blood Clots Deep Vein Thrombosis Pulmonary Embolus Blood Transfusion

GENITAL / URINARY: Frequent Urination Incontinence Bed Wetting Nighttime Urination Urgency

MUSCULOSKELETAL: Neck Pain Back Pain Leg Pain Joint Pain

NEUROLOGIC: Sleepiness Tremors Headaches Dizziness Numbness

PSYCHIATRIC: Restless Sleep Anxiety Forgetfulness Feeling Depressed

Patient Name ________________________________

Race: (please circle one) African-American Asian American Indian Alaskan Native Caucasian Hispanic

Native Hawaiian Pacific Islander or Other: ____

Preferred Language if other than English____

Occupation: ____________________ Full Time or Part Time __Retired __Unemployed __Student __Homemaker

Disabled: Why____

Marital Status: Divorced Married Separated Single Widowed

Live with: Alone Children Parents Significant Other Spouse Group Home Nursing Home

Smoker: ___Never ___Former (Quit Date ___________) ___ Current ___Cigarettes/Cigar ___Packs per Day

Alcohol: ___Never ___Occasional ___Yes; Drinks per Week __________

Caffeinated Beverages: ___Never ___Occasional ___Yes; Drinks per Day __________

Recreational Drugs: ___Never ___Occasional ___Yes; Type__________

Exercise: ___ No ___Yes; Type and how many times per week ____

Living Will: ___ No ___ Yes (Type: DNR, Full Resuscitation, no Vent, Gen Med Care)

Are you Adopted: ___ No ___ Yes

Family History: Do any of your Father, Mother, or Siblings have any of the following:
Please mark M for Mom, D for Dad and S for Siblings

__Alcoholism __Alzheimer's __Attention Deficit __Cancer (type)___________________________

__Dementia __Diabetes __Heart Disease __High Blood Pressure __High Cholesterol

__Huntington's __Migraine __Multiple Sclerosis __Muscle Weakness __Narcolepsy

__Parkinson's __Restless Legs __Seizures __Sleep Apnea __Stroke

Mother: Living Date of Birth_________ Deceased Age _________

Father: Living Date of Birth_________ Deceased Age _________

Medication allergies: ____

Pharmacies used, name and where: ____

____

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

Medication name / Strength / Directions		Medication name / Strength / Directions