Northwest Neurological PLLC

Prevention Clinic Health History

Name: ________________________________ Date of birth: ____________

Your answers will give us a better understanding of your medical concerns and conditions. If you are uncomfortable with any questions, you may leave them blank. Best estimates *are fine;* however, be specific whenever you can.

Personal medical history

Please ***circle*** if you have had any of the following medical problems:

Heart disease   Heat Attack   Stroke   High blood pressure   High Cholesterol

Periperal Vascular Disease   Aortic Aneurysm

Prediabetes   Gestational Diabetes   Polycystic Ovaries   Gout

Diabetes   Alcoholism

Bleeding or Clotting Problems (specify): ________________________________

Rheumatoid arthritis   Cancer (Type): ________________________________

Thyroid problems (specify): Hypothyroidism   Hyperthyroidism

Depression   Anxiety   Memory Concerns: ________________________

Other: ____

Surgical history

Please list all operations you've had:

Appendectomy   Gall Bladder Removal   Tonsillectomy   Thyroidectomy

Cardiac Stents   Cardiac Bypass Surgery   Other vascular procedure: ____________

Joint Replacement Surgery: ________________________________

Other: ____

Have you ever been hospitalized for illness? If so, please tell us when & why:

____

____

____

____

Review of Systems: Please ***circle*** any current symptoms you have *currently* in the lists below.

Constitutional:

- Unexplained weight loss/gain • Excessive thirst • Excessive urination
- *Inability to stand heat* • Inability to stand cold

Eyes:

- Recent changes in vision (Explain.)________________________

Ear/Nose/Throat/Mouth:

• Difficulty hearing or ringing in your ears • Hay fever/allergies •Problems with teeth/gums

Cardiovascular:

- Chest pain/discomfort • Palpitations (irregular or racing heart beat)
- Swelling in feet or legs • Shortness of breath upon exertion or when lying flat
- Pain in extremities with exercise

Respiratory:

- Cough • Wheeze • Difficulty breathing • Snoring • Sleep apnea/ use of CPAP

Gastrointestinal:

- Abdominal pain • Heartburn • Nausea/vomiting • Diarrhea/constipation

Genitourinary:

• Frequency of urination • Urinary incontinence • Erectile dysfunction • Low libido

Neurological:

- Headaches • Light-headedness • Memory loss • Loss of coordination
- Numbness in hands or feet

Skin:

- *Brittle nails • Dry skin • Skin tags • Rashes*
- *Change in skin or hair texture • Easy bruising/bleeding or Unexplained lumps*

Psychiatric:

- Depression • Anxiety/ Panic attacks • Manic episodes
- Anger issues • Problems with sleep

Family History of Medical Conditions

Please list any family members with the following conditions and the age at which conditions were diagnosed (if known).

Heart disease/ Heart attack: ______________________________

Stroke: ______________________________

Diabetes: ______________________________

Dementia: ______________________________

High blood pressure: ______________________________

High cholesterol: ______________________________

Autoimmune Disease: ______________________________

Social history

Tobacco use

- Current smoker? (number of pack per day) ________ Date you quit smoking _________
- *Other current tobacco use*: Pipe; Cigar, Chewing tobacco # of years used _________
- Are you exposed to second-hand smoke? Yes / No For how long _______________

Alcohol use

- Do you drink alcohol? Yes / No How many drinks do you consume per week? ______

  Alcohol type ________________________

- Does your alcohol consumption have you or others concerned? Yes / No

Other:

Caffeine intake: Coffee/Tea ______ cups/day Sodas per day ______ Diet / Regular

Weight: Are you satisfied with your weight? Yes / No What is your goal weight?___________

When you last weighed your goal weight?_________ How long were you at that weight? _______

Nutrition:

How many **daily** servings of the following do you typically consume?

Whole grains _________ Fruits_________ Vegetables __________

How many times in one week do you consume the following items? _____Eggs _____Fish

_____Chicken/turkey _____Red meat(beef/pork) _____Butter _____Margarine

______Other high fat dairy products _____Fried foods _____High fat snacks

How often do you eat out? __________ Foods you typically order? ____________________

Medications: Please list all prescription and non-prescription medications, vitamins and herbs.

Medication/Supplements Dose (milligrams per pill, doses per day) Start date Reason

____
____
____
____
____
____
____
____
____

(*Please use back of form if you need additional space.)*

Allergies or reactions to medicines:

____
____
____
____
____

Thank you for taking the time to provide us this valuable information