Associated Neurology Medical Group, Inc.
Health Questionnaire

Note to patient: This form is a part of your medical record

Name: _____ **Age:** _____ **Date:** _____

Reason for visit: _____

Past Medical History: Other than the condition you are being evaluated for today, list all of your medical problems including everything for which you take medication.
_____
_____
_____

Height _____ **Weight** _____

Medications: (List all medications you are taking and the doses)
_____
_____
_____

Allergies: (List all medications to which you are allergic)
Example: Sulfa, Penicillin, Codeine, Aspirin
_____

Family history: List illnesses in your blood relatives and that person's relationship to you
_____

Social history: ☐married ☐domestic partner ☐single ☐divorced ☐widowed ☐other
Live with: ☐spouse ☐partner ☐friend ☐parents ☐relatives ☐other ☐alone ☐facility
Do you have children? If so, age and gender _____

How many years of formal education have you completed? _____
Present employment status: ☐full time ☐part time ☐unemployed ☐retired ☐disabled
What is/was your occupation? _____

Do you use caffeine? _____ If so, how much? _____

Do you currently smoke or use tobacco? ☐no ☐yes
If yes, packs per day: _____ for how many years? _____
Did you quit? ☐no ☐ yes If yes, when? _____

Do you drink alcoholic beverages?
☐none ☐1-7 drinks weekly ☐8-14 drinks weekly ☐more than 14 drinks weekly

Are you right or left handed? _____

Patient Demographics (required by insurance)
Race: ☐ American Indian or Alaska ☐ Asian ☐ Black ☐ Caucasian ☐ Declined ☐ Other ☐ Pacific Islander
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined

Primary language spoken:

1. Constitutional
__ sleep disturbance
__ significant weight loss
__ significant weight gain
__ fever
__ severe fatigue

2. Eyes
__ glaucoma
__ cataracts
__ blurred vision
__ visual loss
__ flashing lights
__ double vision

3. Ears, Nose, Throat
__ hearing loss
__ ringing in the ears
__ ear pain
__ lightheadedness
__ vertigo ("room spinning")
__ difficulty swallowing
__ hoarseness/change in voice
__ loss of smell or taste
__ TMJ disorder
__ sinus disease

4. Cardiovascular
__ High blood pressure
__ High cholesterol
__ chest pain
__ heart failure
__ heart murmur
__ abnormal heart rhythm
__ loss of consciousness

5. Respiratory
__ heavy snoring
__ asthma
__ shortness of breath
__ cough

6. Gastrointestinal
__ gastric reflux
__ ulcer disease
__ nausea/vomiting
__ abdominal pain
__ hepatitis
__ liver failure
__ history of GI bleed
__ loss of bowel control

7. Genitourinary
__ kidney stones
__ painful urination
__ loss of bladder control
__ sexual dysfunction

8. Musculoskeletal
__ back pain
__ neck pain
__ radiating pain in arm
__ radiating pain in leg
__ arthritis
__ swollen joints
__ gout

9. Skin
__ rash
__ easy bruising
__ varicose veins

10. Neurologic
__ headache
__ difficulty with speech
__ tingling/numbness
_____ (where)
__ weakness in body
_____ (where)
__ muscle wasting
__ muscle cramps
__ muscle twitching
__ drooping of eyelids
__ involuntary movements
__ difficulty with handwriting
__ incoordination
__ difficulty walking
__ TIA or stroke
__ seizure
__ head injury
__ memory difficulties
__ confusion
_____ (other)

11. Endocrine
__ diabetes
__ thyroid disease

12. Hematologic, lymphatic
__ anemia
__ history of blood clots
__ bleeding disorder
__ past transfusions
_____ (when)

13. Allergic, immunologic
__ allergies (other than medications)
__ immune system disorders

14. Psychiatric
__ anxiety
__ depression
__ mood swings
__ panic attacks
__ hallucinations
__ learning disabilities
__ history of counseling

_____ _____

(Signature of individual completing form) (Relationship to patient)

I have reviewed this form with the patient: _____

(Physician signature/date)