Maine Medical PARTNERS Neurology

Today's Date: _____

MEDICAL HISTORY FORM

Name: _____ Height: _____ Weight: _____

Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Physician: _____

What problem are you here for today? _____

What problems do you have?

__ Diabetes
__ High Blood Pressure
__ Lung Problems
__ Heart Problems
__ Kidney Disease
__ Gastrointestinal
__ Thyroid Problems
__ Arthritis

List all other medical problems:

_____
_____
_____
_____

Surgeries you have had (no dates necessary):

_____
_____
_____

What medications do you currently take? (please include both prescription and over-the-counter medications)

	How much (mg)?	How many times per day?

Do you have allergies to certain medications? ☐ Yes ☐ No

If yes, please name the medication(s) and reaction(s) below:

_____
_____

Marital Status:

__ Single
__ Married
__ Life Partner
__ Separated
__ Divorced
__ Widowed

__ Number of Children

Do you smoke? ☐ Yes ☐ No
If so, how much? ___ packs/day

Do you drink? ☐ Yes ☐ No
If so, how much? ___ per day ___ per week ___ per month

What is your current occupation? _____
Your spouse's occupation? _____

Disabled? ☐ Yes ☐ No
Reason: _____

Family History of Medical/Neurological Problems:

	Age	Problem(s)	Cause of Death
Mother:			
Father:			
Sister(s):			
Brother(s):			

Reviewed by: _____

(OVER)

Name: _____ Date: _____

Have you had any of the following symptoms recently?

	Yes	No	
Neurologic			
			Headache
			Memory Loss
			Fainting/Spells
			Tremor
			Weakness
			Numbness
			Balance Problems
			Vertigo/Dizziness
Psychological			
			Insomnia
			Depression
			Anxiety
			Crying Spells
Eyes			
			Blurred Vision
			Double Vision
			Eye Pain
Ear, Nose & Throat			
			Hearing Loss
			Ear Pain
			Difficulty Swallowing
Musculoskeletal			
			Neck Pain
			Arm Pain
			Back Pain
			Leg Pain
			Joint Pain
Cardiovascular			
			Chest Pain
			Irregular Heartbeat
			Rapid Heartbeat
Genitourinary			
			Bladder Control Problems
			Sexual Problems
			Recent Urinary Infections
Gastrointestinal			
			Diarrhea
			Constipation
			Nausea
			Vomiting
Respiratory			
			Shortness of Breath
			Coughing
Constitutional			
			Recent Fever
			Weight Loss
			Weight Gain

Reviewed by: _____