Texas Health
Neurology Specialists

Date: _____ MRN: _____ (Office Use Only)

Name: _____ DOB: _____

Primary Care Physician: _____ Referring Provider: _____

Reason for Today's Visit: _____

Allergies: _____

_____

Medications: (If you are being referred by a THPG physician, write THPG in section below and skip)

List all current medications, prescription and nonprescription (Example: Aspirin, Herbal Supplements, Vitamin)

Medication	Dosage	Frequency

Medical History (If you are being referred by a THPG physician, write THPG across section below and skip)

	Yes	MM/YYYY		Yes	MM/YYYY
Anemia			Hyperthyroid		
Anxiety			Hypothyroid		
Asthma			Kidney Disease		
Back Problems			Liver Disease		
Breast Cancer			Migraines		
Congestive Heart Failure			Psychiatric		
Coronary Artery Disease			Rheumatoid Arthritis		
Depression			Skin Cancer		
Diabetes			Sleep Apnea		
Emphysema (COPD) or Chronic Bronchitis			Stomach or Peptic Ulcer		
Any Other Lung Disease Not Mentioned			Other Cancer: _____		
Glaucoma			Stroke		
Headaches			Other:		
Heart Disease			Other:		
High Cholesterol			Other:		
Hypertension (High Blood Pressure			Other:		

Name: _____ DOB: _____

Surgical History (If you are being referred by a THPG physician, write THPG in the section below and skip)

Surgery	MM/YYYY	Surgery	MM/YYYY

Family History (If you are being referred by a THPG physician write THPG in the section below and skip)

Disease	Which Family Member
Alzheimer's	
Cancer	
Diabetes	
Huntington's Disease	
Migraine Headaches	
Multiple Sclerosis	
Parkinson's Disease	
Seizures	
Stroke	
Other: _____	

Personal History:

Occupation: _____

Marital Status: Single Married Widowed Separated Divorced

Social History

Your Personal Habits: Do You?	Yes	No	Date Quit	If Yes, How Much/Often
Smoke				
Drink Alcohol				
Use Recreational/Intravenous Street Drugs If Yes, Name of Drug, How Much and How Often				

System Review (Please Circle any of the following that apply to your RECENT health.

Constitution
Fever
Malaise/Fatigue
Weakness
Weight Loss

Hematologic
Ecchymosis (Bruise Easily)
Excessive Bleeding

Ears
Hearing Loss
Tinnitus (Ringing in Ears)

Eyes
Blurred Vision
Double Vision
Vision Loss

Cardiovascular
Chest Pain
Palpitations (Fast Heart Rate)

Respiratory
Wheezing
Shortness of Breath

Gastrointestinal
Abdominal Pain
Constipation
Diarrhea (Chronic)
Melena (Sticky Black Stool)
Nausea
Vomiting

Genitourinary
Urination Frequency
Dysuria (Pain with Urination)
Hematuria (Blood in Urine)
Urgency
Urinary Incontinence (Leakage of Urine)

Musculoskeletal
Back Pain
Joint Pain
Neck Pain
Muscle Cramps Arms/Legs
Myalgia (Muscle Pains)

Neurological
Dizziness
Focal Weakness
Numbness
Seizures
Speech Change
Syncope (Pass Out)
Tingling
Tremor

Psychiatric
Depression
Hallucinations
Insomnia
Memory Loss
Nervous/Anxious

I have read all of the above and I agree that all UNMARKED responses are NOT symptoms that apply to my recent health.

Please Sign: _____ Date: _____