NEUROLOGY SPECIALISTS OF NORTH TEXAS

Texas Health Physicians Group

HEALTH HISTORY FORM

Date:_______________________________________ **MRN:**____________________________
(Office Use Only)

Name:____**DOB:**____________________________________

Primary Care Provider: ______________________________ **Referring Doctor:** ____________________________________

REASON FOR TODAYS VISIT: ____

____

____

____

____

ALLERGIES *List all known allergies and reactions*: ____

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____

____

MEDICATIONS

List all current medications, prescription and nonprescription (EXAMPLE: ASPRIN, HERBALS, VITAMINS):

Medication	Dose	Frequency	Start Date

:

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Name:____**DOB:**____

HEALTH MANAGEMENT:
Please indicate when you last had each of the following::

	Date		Date
Pneumonia Shot		Flu Shot	

MEDICAL HISTORY (*Check all that apply*)

	YES	*MM/YYYY*		*YES*	*MM/YYYY*
Anemia			Kidney Disease		
Anxiety			Liver Disease		
Asthma			Migraines		
Any other lung disease not mentioned			Phlebitis/blood clots		
Back Problems			Psychiatric		
Breast cancer			Rheumatoid arthritis		
Congestive Heart Failure			Seizures		
Coronary Artery Disease			Sexually Transmitted Disease		
Depression			Skin cancer		
Diabetes			Sleep Apnea		
Emphysema (COPD) or Chronic Bronchitis			Stomach or Peptic Ulcer		
Glaucoma			Stroke		
Headaches			Other cancer:		
Heart Disease			Other:		
High Cholesterol			Other:		
Hypertension (High Blood Pressure)			Other:		
Hyperthyroid			Other:		
Hypothyroid			Other:		

SURGICAL HISTORY

Surgery	MM/YYYY	Surgery	MM/YYYY

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Name:____**DOB:**___________________________________

FAMILY HISTORY

Please indicate in the spaces below any family members with a history of: diabetes, heart disease, cancer, emphysema, kidney disease, asthma, bleeding tendencies, anemia, epilepsy, glaucoma, high blood pressure, gout, arthritis, ulcer, stroke, nervous breakdown, gall bladder disease.

Please Mark if Family History Unknown ____________________________

Family Member	Father	Mother	Paternal Granfather	Maternal Grandfather	Paternal Grandmother	Maternal Grandmother	Siblings	Child(ren)
Age if Living								
Age at Time of Death								
Cause of Death								
Alzheimers								
Cancer								
Diabetes								
Heart Attach								
High Blood Pressure								
Hunington's Disease								
Migraine Headaches								
Multiple Sclerosis								
Parkinsons Disease								
Seizures								
Stroke								
Other Illness								

PERSONAL HISTORY:

Occupation: ____

Level of Education: ____

Marital Status: Single Married Widowed Separated Divorced

SOCIAL HISTORY

Your Personal Habits: Do you?	YES	NO	Date Quit	If Yes, how much/how often?
Smoke				
Drink Alcohol				
Use recreational/Intravenous street drugs If Yes, Indicate Name of Drug, How Much and How Often				

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HEALTH HISTORY FORM

NAME:____DOB:____________________________

SYSTEM REVIEW

Instructions: Please circle any of the following that apply to your RECENT health.

Constitution
Fever
Malaise/Fatigue
Weakness
Weight Loss

Skin
Excessive Redness
Itching
Paleness
Rash
Yellowed Skin

Hematologic
Ecchymosis (Bruise Easily)
Excessive Bleeding

HENT
Headaches/Head Pain
Hearing Loss
Tinnitus (ringing in ears)

Eyes
Blurred vision
Double vision
Photophobia(light sensitivity)
Vision Loss

Cardiovascular
Chest pain
Heart Attack
Leg swelling
Palpitations (fast heart beat)

Respiratory
Cough
Shortness of breath
Wheezing

Gastrointestinal
Abdominal pain
Constipation
Diarrhea (Chronic)
Melena (black sticky stool)
Nausea
Vomiting
Vomiting Blood

Genitourinary
Dysuria (pain w/urination)
Flank pain
Frequency
Hematuria (Blood in urine)
Urgency
Urinary Incontinence (Leakage of Urine)

Musculoskeletal
Back Pain
Falls
Joint Pain
Leg Pain when walking
Muscle Cramps Arms/Legs
Myalgias (Muscle Pains)
Neck Pain

Neurologic
Dizziness
Focal weakness
Numbness
Seizures
Sensory change
Speech change
Syncope (passing out)
Tingling
Tremor

Psychiatric
Depression
Hallucinations
Insomnia
Memory loss
Nervous/Anxious
Suicidal Ideas

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: ______________________