# GREAT VALLEY NEUROLOGICAL ASSOCIATES

## PATIENT CONSULTATION HISTORY TO BE COMPLETED BY PATIENT

**TODAY'S DATE:_____**

**PATIENT NAME_____DATE OF BIRTH_____AGE_____**

PRIMARY CARE PHYSICIAN: _____REFERRING PHYSICIAN: _____

OCCUPATION: _____ MARITAL STATUS: S / M / W / D / CO-HABITATE
DOMINATE HAND: RIGHT / LEFT/ AMBIDEXTROUS
SMOKER: Y / N HOW MUCH PER DAY? _____ DID YOU EVER SMOKE? YES / NO
ALCOHOL: Y / N HOW MUCH? _____
HAVE YOU FALLEN IN THE LAST YEAR? YES NO IF YES, HOW MANY TIMES? _____ ANY INJURIES? _____
**REASON FOR TODAY'S VISIT:**

**CURRENT MEDICATIONS AND DOSAGES, INCLUDING VITAMINS AND SUPPLEMENTS (use reverse side if needed)**

**DRUG ALLERGIES: Y/ N IF YES, LIST:**

**PAST MEDICAL HISTORY:**

| | | | | | |
|---|---|---|---|---|---|
| ANEMIA | Y/N | OTHER EYE PROB | Y/N | | |
| ARTHRITIS | Y/N | HEAD INJURY | Y/N | PEPTIC ULCER | Y/N |
| ASTHMA | Y/N | HEART DISEASE | Y/N | SEIZURE | Y/N |
| BACK INJURY | Y/N | HEPATITIS | Y/N | STROKE | Y/N |
| BOWEL DISEASE | Y/N | HIGH B. P. | Y/N | THYROID DISEASE | Y/N |
| DEPRESSION | Y/N | MIGRAINE | Y/N | CANCER | Y/N |
| DIABETES | Y/N | MUSCLE DISEASE | Y/N | TYPE_____ | |
| GLAUCOMA | Y/N | NECK INJURY | Y/N | | |

OTHER, PLEASE LIST:

**MAJOR SURGERY HISTORY**:

| | | | | | |
|---|---|---|---|---|---|
| CABG | Y/N | CAROTID SURGERY | Y/N | HEART SURGERY | Y/N |
| JOINT SURGERY | Y/N | HEART STENTS | Y/N | PACEMAKER | Y/N |
| BRAIN SURGERY | Y/N Type_____ | NECK SURGERY | Y/N | OTHER, LIST: | |
| CANCER SURGERY | Y/N | BACK SURGERY | Y/N | | |

**FAMILY HISTORY: LIST RELATIONSHIP OF AFFECTED FAMILY MEMBER**

| | | | | | |
|---|---|---|---|---|---|
| HEART DISEASE | Y/N_____ | MENTAL ILLNESS | Y/N_____ | PARKINSON'S DISEASE | Y/N _____ |
| MIGRAINE | Y/N_____ | SEIZURES | Y/N_____ | MULTIPLE SCLEROSIS | Y/N_____ |
| CANCER | Y/N_____ | TREMOR | Y/N_____ | NEUROPATHY | Y/N_____ |
| SENILITY/DEMENTIA | Y/N_____ | STROKE | Y/N_____ | | |

OTHER CONDITIONS THAT RUN IN YOUR FAMILY AND FAMILY MEMBER AFFECTED:

**REVIEW OF SYSTEMS: DO YOU HAVE SIGNIFCANT PROBLEMS WITH ANY OF THE FOLLOWING?**

| | | |
|---|---|---|
| o EASY BRUSING/BLEEDING | o WEAKNESS | o IMBALANCE |
| o PALPITATIONS | o HEADACHES | o FEVER |
| o SKIN RASHES | o ABDOMINAL PAIN | |
| o NUMBNESS | o MUSCLE CRAMPS | o URINARY FREQUENCY |
| o NAUSEA/VOMITTING | o NIGHT SWEATS | o CONSTIPATIONDIARRHEA |
| o FAINTING | o BLOOD CLOTS | o MEMORY LOSS |
| o FATIGUE | o TROUBLE BREATHING | o POOR ATTENTION |
| o VISION CHANGES | o SNORING | o DOUBLE VISION |
| o CHEST PAIN | o NIGHT SWEATS | o SPEAKING |
| o HEARING CHANGES | o WEIGHT CHANGE | o SWALLOWING |
| o PAIN IN EXTREMITIES | o NECK PAIN | o APPETITE CHANGES |
| o URINARY INCONTINENCE | o BACK PAIN | o ANXIETY |
| o HEARING CHANGES | o SEASONAL ALLERGIES | o INSOMNIA |
| o VERTIGO/DIZZINESS | o WORD FINDING | |
| o DEPRESSION | o PAIN WITH URINATION | OTHER: |