Cumberland Neurology Group
Medical History Form

Please complete this form before arriving for your first visit to help ensure completeness and accuracy and to avoid time delays at the doctor's office. If you already have your own history or medication forms, please complete this form regardless.

Name **Date of Birth** **Date Completed**

What is the main reason you are seeing the neurologist? (Be very brief)

PAST MEDICAL HISTORY. *Check only those that apply to you. List any others.*

ENDOCRINE	*Past*	*Present*
Cancer	____	____
Cushing's Disease	____	____
Diabetes	____	____
Hyperthyroidism	____	____
Hypothyroidism	____	____
Osteoporosis	____	____
Pituitary Disease	____	____
Other _____		

DERMATOLOGY/HEMATOLOGY/INFECTIOUS		
Anemia	____	____
Bleeding Disorder	____	____
Blood Clotting Disorder	____	____
Deep Vein Thrombosis (DVT)	____	____
HIV-positive	____	____
Leukemia	____	____
Lyme Disease	____	____
Lymphoma	____	____
Skin Cancer	____	____
Syphillis	____	____
Other _____		

GASTROINTESTINAL		
Cancer	____	____
Crohn's disease	____	____
Diverticulosis	____	____
Esophagitis	____	____
Gallbladder Inflammation	____	____
Gallstones	____	____
GERDS / Acid Reflux	____	____
Hepatitis	____	____
Irritable Bowel Syndrome	____	____
Liver Cirrhosis	____	____
Pancreatitis	____	____
Ulcer	____	____
Ulcerative Colitis	____	____
Other _____		

CHILDHOOD		
Birth Trauma	____	____
Cerebral Palsy	____	____
Developmental Disorder	____	____
Learning Disability	____	____
Meningitis	____	____
Polio	____	____
Rheumatic Fever	____	____
Other _____		

NEUROLOGICAL	*Past*	*Present*
Alzheimer's Disease	____	____
Arnold Chiari Malformation	____	____
Arteriovenous Malformation (AVM)	____	____
Bell's Palsy	____	____
Brain Hemorrhage	____	____
Brain Tumor	____	____
Carpal Tunnel Syndrome	____	____
Cerebral Aneurysm	____	____
Dementia	____	____
Dystonia	____	____
Encephalitis	____	____
Epilepsy	____	____
Headaches	____	____
Head Trauma/Injury/Concussion	____	____
Hydrocephalus	____	____
Inherited Neurological Disease (specify) _____		
_____		
_____		
_____		
Meningitis	____	____
Multiple Sclerosis	____	____
Myasthenia Gravis	____	____
Myopathy (Muscle Disease) (specify) _____		
_____		
_____		
_____		
Nerve Injury (specify) _____		
_____		
_____		
_____		
Neuropathy (Nerve Disease) Specify _____		
_____		
_____		
_____		
Optic Neuritis	____	____
Paralysis	____	____
Parkinson's Disease	____	____
Seizure	____	____
Shingles	____	____
Spinal Cord Disorder	____	____
Stroke	____	____
Syncope/Fainting	____	____
Transient Ischemic Attack	____	____
Tremor	____	____
Trigeminal Neuralgia	____	____
Vitiamin B12 Deficiency	____	____
Other _____		

Cumberland Neurology Group
Medical History Form

Name Date of Birth Date Completed

PAST MEDICAL HISTORY. *Check only those that apply to you. List any others.*

EYES/EARS/NOSE/THROAT	*Past*	*Present*
Blindness / Poor Vision	____	____
Cancer	____	____
Cataracts	____	____
Chronic Ear Infection	____	____
Chronic Tinnitus	____	____
Glaucoma	____	____
Hearing Loss / Deafness	____	____
Injury to Eye	____	____
Seasonal Allergie	____	____
Sinusitis	____	____
Vertigo	____	____
Other _____		

CARDIOVASCULAR		
Angina	____	____
Aortic Aneurysm	____	____
Atrial Fibrillation	____	____
Cardiac Stent	____	____
Congestive Heart Failure	____	____
Coronary Artery Disease	____	____
Endocarditis	____	____
Heart Attack	____	____
Heart Murmur	____	____
High Cholesterol/Lipids	____	____
Hypertension	____	____
Hypotension	____	____
Irregular Heart Rate (Arrhythmia)	____	____
Mitral Valve Prolapse	____	____
Rapid Heart Rate (Tachycardia)	____	____
Rheumatic Heart Disease	____	____
Slow Heart Rate (Bradycardia)	____	____
Vascular Disease (Legs-Arms)	____	____
Other _____		

RESPIRATORY		
Asthma	____	____
Cancer	____	____
Chronic Bronchitis	____	____
COPD	____	____
Pneumonia	____	____
Pulmonary Embolism	____	____
Tuberculosis	____	____
Other _____		

GENITOURINARY		
Cancer	____	____
Interstitial Cystitis	____	____
Kidney Stones	____	____
Recurrent Infection	____	____
Renal Failure	____	____
Renal Insufficiency	____	____
Other _____		

MEN ONLY	*Past*	*Present*
Cancer	____	____
Impotence	____	____
Prostate Problems	____	____
Other _____		

SLEEP DISORDERS		
Hypersomnia	____	____
Insomnia	____	____
Parasomnias (Sleep Walking or Talking)	____	____
Sleep Apnea Syndrome	____	____
Restless Leg Sydrome	____	____
Other _____		

WOMEN ONLY		
Endometriosis	____	____
Cancer	____	____
Menstrual Problems	____	____
Polycystic Ovary Syndrome	____	____
Other _____		

MUSCULOSKELETAL/IMMUNE/RHEUMATOLOGIC		
Chronic Fatique Sydrome	____	____
Connective Tissue Disease	____	____
Degenerative Spine Disease	____	____
Neck / Low Back	____	____
Fibromyalgia	____	____
Gout	____	____
Lupus	____	____
Osteoarthritis	____	____
Osteomyelitis	____	____
Rheumatoid Arthritis	____	____
Scarcoidosis	____	____
Sjogren's Syndrome	____	____
Vasculitis	____	____
Other _____		

PSYCHOLOGICAL		
Anxiety	____	____
Bipolar Disorder	____	____
Claustrophobia	____	____
Depression	____	____
Dysthymic Disorder	____	____
Obsessive-Compulsive Disorder	____	____
Panic Attacks	____	____
Personality Disorder (Specify) _____		
_____		
Pseudoseizures	____	____
Post Traumatic Stress Disorder	____	____
Schizophrenia	____	____
Somatization Disorder	____	____
Other _____		

OTHER ____ _____

_____

_____

Cumberland Neurology Group

Name **Date of Birth** **Date Completed**

Please list all surgical procedures, approximate dates and name of surgeon.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list all of your current physicians and their specialty. Please also indicate counselors, psychologists and psychiatrists.

_____ _____

_____ _____

_____ _____

FAMILY MEDICAL HISTORY *Check only those that apply to your family.*

Hypertension	____	Brain Tumor	____	Psychiatric Illness	____
Coronary Artery Disease	____	Epilepsy	____	Suicide	____
Heart Attack	____	Migraine	____	Parkinson's Disease	____
Heart Surgery	____	Diabetes	____	Muscle Disease	____
Other Heart Disease	____	Cancer	____	Peripheral Nerve Disease	____
High Cholesterol	____	Tuberculosis	____	Multiple Sclerosis	____
Peripheral Vascular Disease	____	Asthma	____	Other _____	
Kidney Disease	____	Other Lung Disease	____	_____	
Stroke	____	Ulcer Disease	____	_____	

SOCIAL HISTORY

Smoking: Y / N ____ cigarette/day ____ # of years you have smoked
If you quit: ____ year you quit ____ year's smoked

Alcohol: Y / N _____ times/week **or** _____ times/month
History of alcohol dependence Y / N

Illicit (recreational) drug use: Current? Y / N Past? Y / N
If current, what kind? _____ How often? _____
If past, what kind? _____ How often? _____

Caffeinated beverages Y / N How many per day? _____

Marital status: ___single ___married ___divorced ___widow/er?
Current spouse's name _____
Spouse's Occupation _____
Children: how many? _____ Biological _____ Ages
_____ Step _____ Ages
_____ Adopted _____ Ages

Were you adopted? Y / N

Employment:
Are you currently employed? Y / N
Current Job Title _____
Duties _____
If you are not working, is it due to?
Injury: Y / N If yes, specify _____
Illness Y / N If yes, specify _____
Other _____
Retired Y / N
Was Never Employed Y / N
Currently on **(Check All That Apply)**
Short-Term Disability _____
Long-Term Disability _____
Medical Leave _____
Workers Comp _____

Education:
High school graduate? Y / N
Noncollege Certificates? Y / N
College/University Y / N
Did you graduate? Y / N
Major _____
Post graduate? Y / N
Specialty/Area of Study _____
Military Service? Y / N

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MEDICATIONS

Patient Name _____ Date of Birth _____

Pharmacy Name _____ Pharmacy Telephone # _____

Name of Medication: *(Include birth control, hormone replacement, diet pills, and over the counter medication.)*	**Exact Dose** *(mg, mcg, tsp)* of ***each*** pill, suppository or injection. *(The dose of **each** pill is on the bottle.)*	At what times do you take the medication each day & how many pills each time? *(specify if other than daily)*	**Who prescribed medication?** *(The Doctor's name is always on the bottle.)*	**How long?**
Example: *Gabapentin*	Example: *300 mg*	Example: *7 AM 1 pill, 2 PM 1 pill, bedtime 2 pills*	Example: *Dr. Smith*	Example: *2 years*

Cumberland Neurology Group

Name **Date of Birth** **Date Completed**

DRUG ALLERGIES OR ADVERSE REACTIONS:
Name of drug and describe the reaction for each drug.

Drug _____ Reaction _____

Drug _____ Reaction _____

Drug _____ Reaction _____

Drug _____ Reaction _____

Drug _____ Reaction _____

Drug _____ Reaction _____

Drug _____ Reaction _____

Drug _____ Reaction _____

STUDIES: Approximate date and place of procedure and who ordered it.

MRI of head: Y / N Date _____ Place _____ Who ordered it? _____

MRI of neck: Y / N Date _____ Place _____ Who ordered it? _____

CT scan of head: Y / N Date _____ Place _____ Who ordered it? _____

Spinal tap: Y / N Date _____ Place _____ Who ordered it? _____

Nerve conduction study/EMG test: Y / N Date _____ Place _____ Who ordered it? _____

EEG: Y / N Date _____ Place _____ Who ordered it? _____

Other: _____ Place _____ Who ordered it? _____

Other: _____ Place _____ Who ordered it? _____

Other: _____ Place _____ Who ordered it? _____

Cumberland Neurology Group

Name **Date of Birth** **Date Completed**

REVIEW OF SYMPTOMS - *Check only those that apply to you.*

NEUROLOGICAL	*Past*	*Present*
Abnormal Movements	____	____
Confusion	____	____
Clumsiness	____	____
Disorientation	____	____
Dizziness	____	____
Eyelid / Face Droop	____	____
Face Pain	____	____
Falling	____	____
Fainting	____	____
General Weakness	____	____
Head Injury	____	____
Headaches	____	____
Imbalance	____	____
Memory Loss	____	____
Muscle Cramps	____	____
Muscle Twitching	____	____
Numbness	____	____
Paralysis	____	____
Pain in Limb	____	____
Shaking/Tremor	____	____
Slurred Speech	____	____
Stiffness	____	____
Tingling/Burning	____	____
Trouble Swallowing	____	____
Trouble Walking	____	____
Weakness of Limb(s) Specify _____		
_____		
_____		
Word Finding Difficulty	____	____
Other _____		

CARDIOVASCULAR		
Abnormal Treadmill Test	____	____
Chest Pain	____	____
Cold Hands/Feet	____	____
Fast Heart Rate	____	____
Irregular Heartbeat	____	____
Leg Cramps at Night	____	____
Low Blood Pressure	____	____
Shortness of Breath	____	____
Slow Heart Rate	____	____
Swollen Ankle/Feet	____	____
Other _____		

GASTROINTESTINAL		
Abdominal Pain	____	____
Black Stool	____	____
Blood in Stool	____	____
Chronic Constipation	____	____
Chronic Diarrhea	____	____
Heartburn/Indigestion	____	____
Jaundice/Yellow	____	____
Nausea	____	____
Vomiting Blood	____	____
Other _____		

WOMEN ONLY	*Past*	*Present*
Menopause	____	____
Menstrual Problems	____	____
Pelvic Pain	____	____
PMS	____	____
Pregnancy	____	____
Other _____		

MUSCLE/BONES/IMMUNE/RHEUMATOLOGIC		
Allergy Problems	____	____
Chronic Back Pain	____	____
Chronic Fatigue	____	____
Chronic Neck Pain	____	____
Chronic Muscle Pain	____	____
Deformity	____	____
Joint Pain	____	____
Swollen Joints	____	____
Other _____		

ENDOCRINE		
Abnormal Hair Growth	____	____
Abnormal Thirst	____	____
Breast Discharge	____	____
Chronic Fatigue	____	____
Frequent Urination	____	____
Other _____		

VISION/HEARING/NOSE/THROAT		
Blindness	____	____
Blurred Vision	____	____
Chronic Ear Pain	____	____
Deafness	____	____
Discharge from nose	____	____
Double Vision	____	____
Ear Drainage	____	____
Eye Drainage	____	____
Eye Irritation/Redness	____	____
Eye Pain	____	____
Glasses/Contacts	____	____
Hearing Loss	____	____
Hoarseness	____	____
Injury to Eye/Ear	____	____
Ringing in Ears	____	____
Sinus Pressure	____	____
Spinning Sensation	____	____
Sudden Change in Vision	____	____
Other _____		

GENITOURINARY		
Blood in Urine	____	____
Difficult Urination	____	____
Frequent Urination	____	____
Incontinence of Urine	____	____
Painful Urination	____	____
Other _____		

Cumberland Neurology Group

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REVIEW OF SYMPTOMS - *Check only those that apply to you.*

MEN ONLY	*Past*	*Present*
Impotence	____	____
Prostate Problems	____	____
Other _____		

DERMATOLOGY/HEMATOLOGY/INFECTIONS		
Bleeding	____	____
Bruise Easily	____	____
Fever	____	____
Insect Bites	____	____
Skin Rash	____	____
Swelling of Lymph Nodes	____	____
Swelling / Warmth	____	____
Other _____		

PSYCHOLOGICAL		
Anger Outburst	____	____
Chronic Anxiety	____	____
Decreased/ Increased Appetite	____	____
Decreased/ Increased Sex Drive	____	____
Depression	____	____
Dysfunctional	____	____
Fear of Closed in Spaces	____	____
Fear of Crowds	____	____
Guilt	____	____
Hallucinations	____	____
Hearing Voices	____	____
Inability to Concentrate	____	____
Inability to Cope	____	____
Inconsolable	____	____
Irritability	____	____
Lack of Energy	____	____
Lack of Interest/Ambition	____	____
Overwhelmed	____	____
Panic Attacks	____	____
Paranoia	____	____
Physical Abuse	____	____
Poor Memory	____	____
Poor Relations with Family	____	____
Poor Relations with Friends	____	____
Problems with Sleep	____	____

PSYCHOLOGICAL (cont.)	*Past*	*Present*
Racing Thoughts	____	____
Rape	____	____
Sadness	____	____
Self Cutting / Injury	____	____
Severe Marital Problems	____	____
Sexual Abuse	____	____
Stressed	____	____
Stutter	____	____
Suicide Attempt	____	____
Thoughts of Suicide	____	____
Other _____		

CONSTITUTIONAL:		
Fever	____	____
Night Sweats	____	____
Weight Loss / Gain	____	____

RESPIRATORY		
Chronic Cough	____	____
Cough up Blood	____	____
Frequent/ Respiratory Infections	____	____
Shortness of Breath	____	____
Wheezing	____	____

SLEEP:		
Early Awakening	____	____
Excessive Daytime Sleepiness	____	____
Excessive Daytime Tiredness	____	____
Mind Racing at Bedtime	____	____
Pauses in Breathing While Asleep	____	____
Restless Legs at Bedtime	____	____
Sleep Walking	____	____
Sleep Talking	____	____
Snoring	____	____
Trouble Falling Asleep	____	____
Trouble Staying Asleep/ Frequent Arousals	____	____
Other _____		

Physician Signature _____ ***Date*** _____