HEALTH HISTORY QUESTIONNAIRE

Form Completed By: Patient ☐ Family Member ☐ Other ☐

Name: ____________________

Reason for visit: ____________________ Age: ________

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PAST HISTORY (have you had)

YES NO
- ☐ ☐ Seizure Disorder
- ☐ ☐ Stroke /TIA
- ☐ ☐ Congestive Heart Failure
- ☐ ☐ Heart Attack
  When: ____________
- ☐ ☐ High Blood Pressure
- ☐ ☐ Bleeding/ Clotting Problems
- ☐ ☐ Diabetes/ Hypoglycemia
- ☐ ☐ Thyroid Problems
- ☐ ☐ Arthritis/ Limited Motion
- ☐ ☐ Cancer/ Tumor
  Where: ____________
- ☐ ☐ Chemotherapy/ Radiation
- ☐ ☐ Depression, Alcoholism, Suicide

List History of Hospitalization, Surgeries, and Trauma: ____________

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FAMILY HISTORY

YES NO
- ☐ ☐ Heart Disease
- ☐ ☐ Cancer
- ☐ ☐ Stroke
- ☐ ☐ Diabetes
- ☐ ☐ High Blood Pressure
- ☐ ☐ Depression, Alcoholism, Suicide

SOCIAL HISTORY

YES NO
- ☐ ☐ Do/ Did you Smoke?
  How much: ____ How Long: _____
  When did you quit: ____________
- ☐ ☐ Do you drink Alcohol?
  How much: ____________
  Last drink: ____________
- ☐ ☐ Do you drink Caffeine?
  How much: ____________

REVIEW OF SYSTEMS (Have you had any of the following within 2 weeks)

YES NO General Symptoms
- ☐ ☐ Fever/ Chills/ Night Sweats
- ☐ ☐ Weakness/ Fatigue

YES NO Neurological
- ☐ ☐ Headache
- ☐ ☐ Weakness
  Where: ____________
- ☐ ☐ Tingling
  Where: ____________
  How often: ____________
- ☐ ☐ Seizures
- ☐ ☐ Numbness
- ☐ ☐ Head Injury
- ☐ ☐ Other :____________

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YES NO Cardiovascular
- ☐ ☐ Chest Pain
- ☐ ☐ Ankle Swelling
- ☐ ☐ Murmur
- ☐ ☐ Palpitation/ Arrhythmias
- ☐ ☐ Easy Bleeding/ Bruising
- ☐ ☐ High Cholesterol

YES NO Pulmonary
- ☐ ☐ Breathing Problems Shortness of Breath
- ☐ ☐ Cough/ Productive
- ☐ ☐ Sleep Apnea/ CPAP
- ☐ ☐ TB/ Last PPD ________
  Result: ____________

YES NO Gastrointestinal/ Genitourinary
- ☐ ☐ Black/ Bloody Stool
- ☐ ☐ Loss of Bowel Control
- ☐ ☐ Loss of Bladder Control
- ☐ ☐ Currently Pregnant
- ☐ ☐ Sexually Transmitted Diseases

YES NO Musculoskeletal
- ☐ ☐ Joint Pain/ Arthritis
- ☐ ☐ Limited Motion
- ☐ ☐ Back/ Neck Pain
- ☐ ☐ Fracture, Contractures, Prostheses

ANESTHESIA QUESTIONS (At any time)

YES NO Anesthesia/ Surgical
- ☐ ☐ Previous Anesthesia Problem
- ☐ ☐ Blood Transfusion Reaction
- ☐ ☐ Trouble Opening Mouth
- ☐ ☐ Limitation of Neck/ Jaw Movement

YES NO Skin
- ☐ ☐ Skin Rash/ Sores
- ☐ ☐ Change in Color of Skin
- ☐ ☐ Swollen Skin/ Glands/ Limbs

Comments: ____________________

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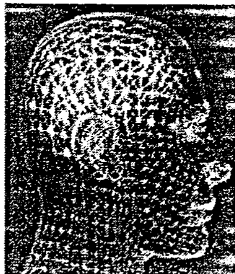

NEUROSCIENCES DEPARTMENT

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