Lake Norman Neurology
Piedmont HealthCare

MEDICAL HISTORY

Full Name:_____Date:_____

Age:_____Birth Date:_____ Height___ Weight___ Occupation:_____

How you heard about us? Referred by Dr._____Print_____Patient____ Other_____

Family Doctor:(name &address)_____

Marital Status:_____Single ____Married ____Separated ____Divorced ____Widowed

Handedness:____Right ____Left

What problem would you like us to solve? _____

_____

Personal Habits

Do you smoke? __No__Yes __Pipe __Cigars __Cigarettes Daily Amt.? ____pks

Do you drink alcohol? __No __Yes Daily Amount:_____ How long?_____

Do you drink beer? __No __Yes Daily Amount:_____ How long? _____

Do you drink coffee? __No __Yes Daily Amount:_____ How long? _____

Do you drink tea? __No __Yes Daily Amount _____ How long? _____

Do you drink caffeinated soft drinks? __No __Yes Daily Amount:____ How long?____

Past Medical History

List any operations you have had including dates:

_____

List any other hospital admissions, dates, and diagnoses:

_____

Other serious illnesses(not requiring hospitalization) with dates:

_____

List any serious injuries you have had including dates:

_____

Check if you have had: __Heart Attack __High Cholesterol __Diabetes __High Blood Pressure __Thyroid Trouble __Stroke
Other medical history:

_____

_____

Family History

Father Age: Age at death: Cause of death:

Mother Age: Age at death: Cause of death:

Check if any Blood Relative has had: __Snoring __Heart Trouble __Diabetes __Migraine Headaches __Cancer __Nervous Breakdown __Kidney Disease __ HighBlood Pressure __Stroke __Your problem

REVIEW OF SYSTEMS: Check YES or NO for each question or check all that apply

Do you now or did you in the past have trouble with:

HEADACHES: __No __Yes

a. How often? __Daily __Weekly __Monthly __ Other
b. Major Pain: __Front __Back __One Side __All Over __ Other
c. When did headaches first begin? _____
d. Do they wake you from sleep? __Never __Sometimes __Other
e. With headaches? __Nausea __Blurred Vision__Lost Vision __Vomitting __Spots before eyes __Numbness

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__PASSING OUT __FAINTING __CONVULSIONS __SEIZURES

a. How often? __Daily __Weekly __Monthly __Other
b. When in the day do the spells usually occur? _____
c. Do you: __Fall __Get Stiff __Bite Tounge __Shake __Jerk __Turn Blue __Make Noise __Lose control of kidneys

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TROUBLE WITH EYES: __No __Yes

a. Sudden Blindness in one eye for 5-10 minutes: __No __Yes (__Right __Left)
b. Double Vision: Objects are separated __Up __Down __Sideways
c. Lid droops: __Left __Right __Both
d. Do you wear glasses or contact lenses? __No __Yes

HAVE YOU EVER HAD THESE PROBLEMS?

a. Sudden loss of use for 5-10 minutes of: __Arm __Leg (__Right __Left)
b. Sudden loss of speech or ability to understand for 5-10 minutes: __No __Yes
c. Been numb in: __Arm __Leg (__Right __Left __Both)
d. Had trouble with (check all that apply): __Saying words __Thinking of words __Concentrating __Thinking __Memory __Pronouncing words
e. Had trouble with __Walking __Tremors __Coordination __Claustrophobia

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__No problems with anything listed in this section

DIFFICULTY WITH: __Breathing through the nose __Eating __Drinking __Tasting __Hoarseness __Swallowing __Chewing __Smelling __Choking __None of these things

TROUBLE WITH HEARING: __No __Yes

a. Noises or ringing in the ear: __Right __Left
b. Loss of hearing: __Right __Left __Both How long? _____

STOMACH TROUBLE: __No __Yes

__Poor Appetite __Vomiting Blood __Stomach Pain __Nausea __Blood in Stool __Change in bowel habit __Hemorrhoids __Diarrhea __Liver Trouble __Ribbon-like stools __Ulcers __Constipation __Black stool

TROUBLE WITH KIDNEYS & GENITAL ORGANS: __No __Yes

__Getting up more than once per night to urinate __Loss of kidney control __Prostate trouble __Dribbling __Trouble starting kidneys __Impotence __Kidney stones __Voiding frequently __Bedwetting __Menstrual Problems

TROUBLE WITH BACK, NECK OR JOINTS: __No __Yes

a. Back Pain: __Worse with Cough __Worse with Sneeze __Going into legs (_Right _Left _Both) How Long? _____
b. Neck pain: __Going into arms __Going into fingers (_Right _Left _Both) How long?_____
c. Swollen or Tender joints? __No __Yes – Which joints_____

TROUBLE WITH SKIN: __No __Yes __Rash __Lumps __Birthmarks __Other:_____

HAVE YOU RECENTLY: __Lost weight __lbs. __Been depressed __Had crying spells __Gained weight __lbs. __Been nervous __Had night sweats

SLEEP HISTORY: Do you or have you been told you: __Snor/gasp when asleep __Loud snoring __Breathing stops, struggle for breath __Tossing, turning, thrashing __Fall asleep at work or school __Wake feeling unable to move/paralyzed __Morning headaches __Difficulty falling asleep __Excessive sleepiness during the day __Weird dreamlike state while awake __ Frequent awakening __ Legs feel jumpy/jerky.