RMH | NEUROLOGY CARE

PATIENT HISTORY FORM

1428 S. Main Street, Suite 4, Ottawa, KS 66067
833-RMH-CARE or 785-242-4003

Name: _____ Date of Birth: _____ Today's Date: _____
Reason for Visit: _____
Previous Surgeries/Medical History (include date):_____
_____
Medications: ❑ *See attached list* _____
Allergies:_____ Do you have any implanted devices? ❑ Yes ❑ No

PATIENT SOCIAL HISTORY: Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Use of alcohol: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily
Use of tobacco: ❑ Never ❑ Previously, but quit_____ ❑ Current packs/day: _____
Use of drugs: ❑ Never ❑ Type/Frequency: _____
Occupational/Work History: _____

FAMILY MEDICAL HISTORY: ❑ Adopted

	Age	*Diseases*	*If Deceased, Cause of Death*
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____

PLEASE INDICATE ANY PERSONAL HISTORY BELOW:

CONSTITUTIONAL SYMPTOMS
Recent weight change .....❑ Yes ❑ No
Decreased appetite .....❑ Yes ❑ No
Headaches .....❑ Yes ❑ No

EYES
Wear glasses/contact lenses .....❑ Yes ❑ No
Blurred or double vision.....❑ Yes ❑ No
Glaucoma/cataracts.....❑ Yes ❑ No

EARS/NOSE/THROAT
Hearing loss or ringing .....❑ Yes ❑ No
Earaches or drainage .....❑ Yes ❑ No
Nose bleeds.....❑ Yes ❑ No

CARDIOVASCULAR
Palpitation .....❑ Yes ❑ No
Swelling of feet, ankles or hands .....❑ Yes ❑ No

RESPIRATORY
Chronic or frequent coughs .....❑ Yes ❑ No
Asthma or wheezing.....❑ Yes ❑ No

GASTROINTESTINAL
Loss of appetite .....❑ Yes ❑ No
Change in bowel movements .....❑ Yes ❑ No
Nausea or vomiting .....❑ Yes ❑ No

GENITOURINARY
Frequent urination .....❑ Yes ❑ No
Burning or painful urination .....❑ Yes ❑ No

MUSCULOSKELETAL
Joint stiffness or swelling.....❑ Yes ❑ No
Weakness of muscles or joints.....❑ Yes ❑ No
Joint pain.....❑ Yes ❑ No

INTEGUMENTARY (skin, breast)
Rash or itching .....❑ Yes ❑ No
Change in skin color .....❑ Yes ❑ No

NEUROLOGICAL
Frequent or recurring headaches .....❑ Yes ❑ No
Light headed or dizzy.....❑ Yes ❑ No
Convulsions or seizures .....❑ Yes ❑ No
Numbness or tingling sensations .....❑ Yes ❑ No

PSYCHIATRIC
Nervousness .....❑ Yes ❑ No
Depression .....❑ Yes ❑ No
Insomnia.....❑ Yes ❑ No

ENDOCRINE
Glandular or hormone problem .....❑ Yes ❑ No
Thyroid disease.....❑ Yes ❑ No

HEMATOLOGICAL / LYMPHATIC
Slow to heal after cuts .....❑ Yes ❑ No
Bleeding or bruising tendency .....❑ Yes ❑ No
Anemia.....❑ Yes ❑ No

ALLERGIC / IMMUNOLOGIC
History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics .....❑ Yes ❑ No
Morphine, Demerol or other narcotics .....❑ Yes ❑ No
Other drugs / medications: _____
Environmental allergies:_____

Reviewed By: _____

Date: _____