MUSC Neurology Services

(Please bring this completed form)

Please complete the questionnaire below to ensure that we have full and complete information concerning your health background. Thank you.

Appt. Date:____________________
*With Dr.:*____________________
Appt. Time:____________________

Name:______________________________________Age:________Marital Status__________________
Why have you come to see us today?____
____
How long have you had this problem?____
Neurological Symptoms: Problems with memory?______________________Changes in behavior or personality?__________Seizures or loss of consciousness?________________Head injury?__________
Injury to spine?__________ Neck or back pain?__________Pain radiating into arm?____________
Into leg?_____________History of stroke or warning of stroke?_______________Changes in sense of taste or smell?_________Vision?__________Hearing?__________Dizziness?___________Headache?
_______Migraine?________Problems with walking or balance?______________Weakness?_________
If so, what part of you is affected?________________________________Loss or change in sensation (feeling)?_____________Where?____
Medical History: Who referred you to our care?____
Address/phone#:____
Previous hospitalization and/or operations?____
____
Current Medications:____
____
____
Drug Allergies:____
Significant Injuries?____
Pregnancies?______________Deliveries?_____________Miscarriages/abortions?_____________Last menstrual period?____________Do you use tobacco?__________Amount?______________For how many years?___________Alcohol?_________Amount?____________For how many years?_________
Street drugs?__________________***Review of systems:*** Have you had any problems with:
Ears?_________Nose?__________Throat?_________Sinuses?_________Hearing?_________Vertigo or dizziness?_________Vision?__________Breathing?____________Lungs?___________Heart?__________
Circulation?___________Chewing?_________Swallowing?__________Digestion?____________Bowel movements or habits?_____________Problems with bladder control?___________Changes in sexual function or interest in sex?___________Abnormality of menstrual periods? _______________Anemia?
_________Other blood disorders?___________Cancer?____________Rashes or other skin problems?
_________Joint or bone problems?_____________Psychological or psychiatric problems?__________

Social History: Where were you born?__________________________Education_________________
Current Occupation:___________________________Prior work?__________________________Foreign Travel?__________Who lives in your household?____
____What is your leisure/recreational activity?
____
Family History: Please list illness, including neurological illnesses, typical of your family (to include your parents, grandparents, brothers or sisters, and your children):_____________________________
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COMPLETED BY:____________________________________**DATE:** _____________________