ROSENFELD
NEUROLOGY and SLEEP

Medical History **Today's Date:**

Patient Name: ____ Pharmacy: _____________________

Referring MD: __________________________________ Primary Care MD: ____________________________

Chief Complaint
How would you describe the reason/problem for your visit?
____

History of Present Illness
When did the problem start? _____________________________ Is it getting: **BETTER/WORSE/SAME**
Have you seen another MD for this problem? **YES/NO** If yes, what MD and when? ______________________
Have you had any testing for this problem? YES/NO (X-ray, MRI, CT Scan, EMG, EEG, labwork)
If yes, when and where: ____

Past Medical History

Have you ever been diagnosed or treated for any of the following conditions? Circle all that apply.

Asthma	Dizziness/Vertigo	High/Low Blood Pressure	Swelling in Arms/Legs
Allergies	Drug Abuse	Low Blood Sugar	STD*
Autism	Ear Infections	Hearing Changes*	Skin Condition
Aneurysm	Eye Disease	Kidney Condition*	Suicidal Thoughts
Arthritis	Epilepsy/Seizures	Meningitis	Thyroid Disease
Anorexia/Bulimia	Fainting/Syncope	Mental Retardation	Tremors/Shaking
ADD	Fibromyalgia	Mental Illness	Urinary/Bowel Conditions
Anxiety	Genetic Disorder	Muscle Condition*	Visual Disturbances
Balance Trouble	Glaucoma	Multiple Sclerosis	Vascular Conditions*
Bi-Polar Disorder	Hallucinations*	Obsessive Compulsive D/O	
Cerebral Palsy	Headache/Migraine	Tinnitus (ringing in ears)	
Depression	Head Injury*	Spine Disorder	
Diabetes	Heart Disease	Stroke/TIA	

*Please explain: ____

Do you have an implant? YES/NO If yes, please explain: ____

Previous Hospitalizations/Surgeries:

Reason:	Date:	Location:
1.		
2.		
3.		

Medications: List all Prescriptions, Vitamins, Supplements, and Over the Counter Medications with their dosage and how often you take it.

Name: Dosage: How often:

____

____

____

____

____

Drug Allergies: please include the name of the medication and reaction.

Drug Name: Reaction:

____

____

Family History: Please check any major medical conditions that run in your immediate biological family (Mother, Father, Grandparents, Aunt, Uncle, Brother, Sister) and indicate your relationship to that person.

	Condition:	**Relative:**		**Condition:**	**Relative:**
	Asthma			High/Low Blood Pressure	
	Arthritis			Mental Illness	
	Cancer			Muscle Disease	
	Diabetes			Sickle Cell Disease	
	Epilepsy/Seizures			Stroke	
	Headache/Migraine			Thyroid Disease	
	Heart Attack/Disease			Other:	

Personal/Social History: Present Past How often/How much?

Tobacco Use: YES/NO YES/NO ____________________________

Alcohol Use: YES/NO YES/NO ____________________________

Exercise: YES/NO YES/NO ____________________________

Illicit Drug Use: YES/NO YES/NO ____________________________

Do you practice any diet restrictions? YES/NO If yes, please explain: _________________________________

Have you been a victim of physical abuse resulting in injuries? YES/NO If yes, please explain: _____________

____

Have you been involved in a motor vehicle accident resulting in injuries? YES/NO If yes, please explain: ____

____

Are there any other injuries, unusual stress or safety issues we should be aware of? YES/NO If yes, please explain: ____

Review of Systems: Please circle any symptoms you have experienced in the past MONTH.

Cardiac:
High Blood Pressure
Heart palpitations

Ear/Nose/Mouth/Throat
Snoring
Difficulty swallowing/choking

Eyes:
Drooping Eyelids
Blurred/Double Vision

Respiratory:
Shortness of Breath
Upper Respiratory Infection

Gastrointestinal:
Nausea
Vomiting

Skin/Breast/Chest:
Rash
Itching

Psychiatric:
Depression
Anxiety

Endocrine:
Changes in Hair
Excessive Hunger/Thirst

Allergic/Immunologic:
Problems with immunity
Seasonal Allergies

Neurological:
Problems walking/balance
Numbness
Seizures
Back/Neck Pain
Tremors
Memory Loss
Excessive Drowsiness
Dizziness/Vertigo
Loss of Consciousness
Changes in Concentration
Headache/Migraine

____ ________________________________

Patient Signature Date

____

Guardian/Caregiver Signature (if patient is minor/unable)

☐ **Above Reviewed and Discussed with Patient** ☐ **All Systems Negative**

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MD or Clinical Staff Signature