NORTHSIDE NEUROLOGY

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Scott D. Cooper, M.D.

Patient Name: ______________________ Date of Birth: ______________

Chief Complaint: ______________________ Referring Doctor: ______________________

Have you ever had any of the following MEDICAL PROBLEMS? *(Please check if you have)*

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart failure
- ☐ Heart attack
- ☐ Irregular heartbeat
- ☐ Asthma / Emphysema
- ☐ Sleep apnea
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Anxiety
- ☐ Depression
- ☐ Anemia
- ☐ Blood disorders
- ☐ Thyroid disease
- ☐ Sinus problems
- ☐ Chronic allergies
- ☐ Stroke
- ☐ Seizures
- ☐ Migraines
- ☐ Parkinsons
- ☐ Head trauma
- ☐ Neck pain
- ☐ Back pain
- ☐ Vertigo
- ☐ Restless legs
- ☐ Ulcers
- ☐ Intestinal disease
- ☐ Lupus
- ☐ Arthritis
- ☐ Joint pain
- ☐ HIV positive
- ☐ Lyme disease
- ☐ Persistent cough
- ☐ Drug or alcohol abuse
- ☐ Cancer
  Type: ______________

If other, please describe:

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ALLERGIES:

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Pharmacy Name: ______________________

Pharmacy Phone #: ______________________

SURGICAL HISTORY: ______________________

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MEDICATIONS

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SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: ______________________

Hobbies: ______________________

Please check and fill in the blanks as applicable:

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily

Use of Tobacco: ☐ Never ☐ Yes - if yes, please answer the following:

Type of Tobacco: ☐ Cigarettes ☐ Snuff ☐ Chewing Tobacco

☐ Currently ______________ packs/day

☐ Previously, but quit (when) ______________, ______________ packs/day

Use of Drugs: Type: ______________________

MEDICAL HISTORY QUESTIONNAIRE

FAMILY HISTORY:

Has anyone in your family (blood relatives) had any of the following? *(Please check all boxes that apply)*

	Father	Mother	Siblings	Children	Grandparent
Diabetes	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐
Seizure	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Blood Disorders	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Drug or Alcohol Addiction	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Cancer (please give details)	☐	☐	☐	☐	☐

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REVIEW OF SYSTEMS:

Have you had any of the following problems recently? *(Please check if you have)*

☐ Hearing Loss	☐ Ear Pain/Drainage	☐ Ringing in Ears	☐ Eye Pain
☐ Vision Changes	☐ Nose Bleeds	☐ Allergies/Hay Fever	☐ Sore Throat
☐ Hoarseness	☐ Difficulty Swallowing	☐ Headaches	☐ Dizziness
☐ Balance Problems	☐ Shortness of Breath	☐ Chest Pain	☐ Irregular Heartbeat
☐ Cough	☐ Wheezing	☐ Joint Pain	☐ Back Problems
☐ Skin Rash	☐ Itchy/Flaky Skin	☐ Dry Skin	☐ Bruising of Skin
☐ Abdominal Pain	☐ Nausea/Vomiting	☐ Diarrhea	☐ Constipation
☐ Mouth Ulcers	☐ Bleeding Gums	☐ Swollen Glands	☐ Muscle Cramps
☐ Numbness/Tingling	☐ Blood in Urine	☐ Difficulty Urinating	☐ Painful Urination
☐ Blood in Stool	☐ Memory Loss	☐ Sleep Disturbances	☐ Lack of Concentration

☐ Other: ____

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