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Woodlands Neurology Clinic



NEW PATIENT HEALTH HISTORY

Patient Name _____ Today's Date _____

Birth Date _____ Age _____ Reason for appointment? _____

Pharmacy Name & Telephone # _____

How did you find us (referral/internet?) _____

PCP Name & Phone # _____ Date of last visit _____

How would you prefer to be contacted for test results or other communications (circle one)

Online portal or telephone call?

NOTE: If you have prior records you would like Dr. Bonds to review, please bring or send them to our office a few days PRIOR to your appointment.

Please give a brief description of the symptoms you are having, including the duration of your symptoms: _____

Please list any other physicians you have seen for this problem in the past, and what treatment you received:

Please list any prior hospitalizations which you have had, if any, for this problem:

Past Medical History: (please circle)

High Blood Pressure	Diabetes
Stroke	Pacemaker
Heart Disease	
Migraines or recurrent headaches	Lung Disease
Seizures	Kidney Disease
Cancer (Type _____)	Bipolar disorder
Thyroid Problems	Head Injury(s)
Anxiety	Depression

Please list any other medical problems: _____

Past Surgical History

Please list any previous major surgeries and dates of operations:

Type of Surgery	Year of Surgery
_____	_____
_____	_____
_____	_____
_____	_____

Allergies

Please list any drug allergies and any type of allergic reaction that you may have:

Drug	Reaction(s)
_____	_____
_____	_____
_____	_____
_____	_____

Medications

Please list all current medications (prescription and over the counter):

Medication	Strength	Number of times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History:

Are you adopted? Yes or No

What illnesses, if any tend to run in your family? (please list EVEN if your parents are deceased)

	Age	Health Problems
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
	_____	_____
Children	_____	_____
	_____	_____
	_____	_____

Social History

Dominant hand: Right Left Ambidextrous

Education Level-Please indicate the highest grade you have reached: _____

What is your occupation? _____

Average hours of sleep per night _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Health Habits

	Amount	Frequency
<input type="checkbox"/> Caffeine	_____	_____
<input type="checkbox"/> Tobacco	_____	_____
<input type="checkbox"/> Alcohol	_____	_____
<input type="checkbox"/> Other_	_____	_____

If you are 65 or older:

1. have you had a fall in the last year? Yes No
2. **If yes**, how many have you had: 1 or 2 or more.
3. Were you injured by one of these falls? Yes No

Please circle any symptoms that you are experiencing today:

Constitutional: Fever, chills, fatigue

Eyes: Visual disturbance, discharge, pain, redness, photophobia

Ears Nose Mouth Throat: Congestion, dental problem, ear discharge, ear pain, facial swelling, hearing loss, sinus pain, sore throat, ringing

Respiratory: Cough, chest tightness, shortness of breath

Cardiovascular: Chest pain, palpitations (irregular heart beat), swelling in legs or arms

GI: Abdominal pain, blood in stool, constipation, diarrhea, nausea, vomiting

GU: Difficulty urinating, flank pain, frequency, hematuria (blood in urine)

Musculoskeletal: Joint pain, back pain, joint swelling, muscle pain, neck pain, neck stiffness

Neurologic: Memory loss, tremors, numbness or tingling, vertigo, gait problems

Psychiatric: Behavior problem, confusion, dysphoric mood (depression), hallucinations, nervous/anxious

Endocrine: Cold intolerance, heat intolerance, excessive thirst

Hematology/Lymphatic: Swollen lymph nodes, Bruises easily

Skin: rash, wound

Allergic/Immunologic: Environmental allergies, food allergies, immunocompromised