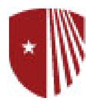

Sound Neurology
Patient History Form

Name: ____

Primary Care/referring physician:____
Date of birth: _____________ **Age:**_________ **Height:**_________ **Weight:**_________
Occupation: ____

Present Illness: Please describe in your own words why you are here today.

____
____
____
____
____
____
____
____

Past Medical History: Please list any medical illnesses or injuries in the following areas.
Eyes: ____
Ears, nose, mouth, throat: ____
Cardiovascular: ____
Respiratory: ____
Gastrointestinal: ____
Genitourinary: ____
Musculoskeletal ____
Skin: ____
Neurological: ____
Psychiatric: ____
Endocrine: ____
Lymphatic: ____
Allergic/Immunological: ____
Infectious disease: ____

Surgical History: Please list any operations and dates.

____
____
____
____
____
____
____

Do you have children? Yes ☐/No ☐ **Last menstrual period:** ____________________

Medications: Please list all medications, hormones, birth control pills, vitamins and over the counter products, including dosage.

____
____
____
____
____
____
____

Allergies: Please list any medications to which you are allergic and the reaction that occurs.

____
____
____
____
____

Social History:

Do you smoke cigarettes? Yes ☐/No ☐ If you quit, how long ago?______________

If yes, how many packs per day? ____________ How many years? ________________

Do you drink alcohol? Yes/No

If yes, what kind and how often? ____

Family History:

Has anyone in your immediate family had any of the following conditions?

Brain/Aneurism:____

Stroke:____

Cancer:____

Diabetes:____

Kidney disease:____

High Blood Pressure:____

Heart disease/attack:____

Incoordination:____

Mental Illness:____

Dementia/memory loss: ____

Migraines/headaches:____

Neuropathy:____

Muscle Disease/weakness:____

Seizure/epilepsy: ____

Tuberculosis:____

Other:____

___________________________________ ________________

Signature **Date**