Stony Brook Medicine

SOUND NEUROLOGY

PATIENT HISTORY FORM

NAME: _____ **DATE**: _____

PRIMARY CARE/REFERRING PHYSCIAN: _____

DATE OF BIRTH: _____ **AGE**: _____ **HEIGHT**: _____ **WEIGHT**: _____

ARE YOU: **LEFT HANDED ☐/ RIGHT HANDED ☐/ SINGLE ☐/ MARRIED ☐/ DIVORCED ☐/ WIDOWED ☐**

PRESENT ILLNESS: **Please describe briefly in your own words why you are here today.**

_____
_____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY: **Please indicate if you have (or ever had) any of the following illnesses including approximate date and treatments:**

ANEMIA/HEMOPHILIA_____
CANCER (TYPE?) _____
DIABETES (HIGH SUGAR) _____
HEART DISEASE/ATTACK_____
HEPATITIS/JAUNDICE_____
HIGH BLOOD PRESSURE_____
SINUS PROBLEMS_____
SYPHYLIS_____
THYROID DISEASE_____
KIDNEY DISEASE_____
POLIO_____
MENINGITIS_____
STROKE_____
TUBERCULOSIS_____
RHEUMATIC FEVER_____
SEIZURE_____
OTHER_____

_____
_____
_____
_____
_____

SERIOUS ILLNESS: Please list any serious injuries including car accidents, broken bones, head trauma, etc., with approximate dates:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

DO YOU WEAR SEAT BELTS? YES ☐ / NO ☐

PAST OPERATIONS (type and approximate dates):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

DO YOU HAVE CHILDREN? YES ☐ / NO ☐ BOYS_____ GIRLS_____ AGE RANGE____

NUMBER OF PREGNANCIES: _____

OTHER COMPLICATIONS? _____

MEDICATIONS: Please list all medications and in what dosage you are taking them, including hormones, birth control pills, vitamins and over-the-counter products.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES: Please list all medications to which you are allergic (or medications that you cannot

tolerate for any reason) and the reaction that occurs. Also, list any seasonal allergies.

_____ _____
_____ _____
_____ _____

OCCUPATION: _____

DO YOU EXERCISE REGULARLY? YES ☐ / NO ☐ **WHAT KIND AND HOW OFTEN?**

_____
_____

AVERAGE STRESS LEVEL (1-LOW, 10 – HIGH): 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

DO YOU SMOKE CIGARETTES? YES ☐ / NO ☐ **IF YES, HOW MANY PACKS PER DAY?** _____

HOW MANY YEARS? _____ **IF YOU HAVE QUIT, HOW LONG AGO?** _____

DO YOU DRINK ALCOHOL? YES ☐ / NO ☐ **IF YES, WHAT KIND AND HOW OFTEN**? _____

_____

IF YOU HAVE QUIT, HOW LONG AGO? _____

WHO IN YOUR FAMILY HAS HAD?
FATHER/MOTHER/SISTER/BROTHER/CHILDREN/OTHER

BRAIN ANEURISM_____

STROKE_____

CANCER_____

DIABETES_____

KIDNEY DISEASE_____

HIGH BLOOD PRESSURE_____

HEARTDISEASE/ATTACK_____

INCOORDINATION_____

MENTAL ILLNESS_____

DEMENTIA/MEMORY LOSS_____

MIGRAINE HEADACHES_____

NEUROPATHY_____

MUSCLE DISEASE/WEAKNESS_____

SEIZURE/EPILEPSY_____

TUBERCULOSIS_____

OTHER_____

_____

PLEASE CHECK ANY OF THE FOLLOWING IF IT IS A SIGNIFICANT PROBLEM FOR YOU NOW OR WAS IN THE PAST:

____HEADACHES
____BLURRED VISION / DOUBLE VISION
____TRANSIENT LOSS OF VISION
____DROOPY EYELIDS
____CONVULVIONS/SYNCOPE
____CHRONIC PAIN
____HEAD INJURY/CONCUSSION
____LOSS OF SMELL/ LOSS OF TASTE
____LOSS OF HEARING/ TINNITUS/ RINGING IN EARS
____DIZZINESS/ VERTIGO
____SLURRED SPEECH
____DIFFICULTY GETTING THE CORRECT WORDS OUT
____DIFFICULTY SWALLOWING
____NUMBNESS/ TINGLING
____TENSENESS/ NERVOUSNESS
____HEAT INTOLERANCE/ COLD INTOLERANCE
____CHRONIC COUGH
____SWELLING OF HANDS/ FEET/ JOINTS
____CHANGE IN SKIN COLOR/ TEXTURE
____WEAKNESS
____PERSISTANT FATIGUE
____MUSCLE CRAMPS
____DIFFICULTY IN WALKING
____UNSTEADY BALANCE
____INVOLUNTARY MUSCLE TWITCHING/ JERKING
____INCOORDINATION/ CLUMSY
____TREMLING/ TREMOR/ SHAKING
____CHANGE IN HANDWRITING
____RECENT WEIGHT LOSS/RECENT WEIGHT GAIN
____MEMORY LOSS
____DIFFICULTY WITH UNUSUAL RESPONSIBILITIES
____CHANGE IN PERSONALITY
____HEARING OR SEEING THINGS
____CONFUSION
____DEPRESSION
____ANXIETY/ CHRONIC WORRY
____SUICIDAL IDEAS

____LOSS OF APPETITE
____SEXUAL DYSFUNCTION
____TROUBLE FALLING/ STAYING ASLEEP
____CHEST PAIN
____SHORTNESS OF BREATH
____PALPITATIONS/ “SKIPPED BEATS”
____CHRONIC CONSTIPATION/CHRONIC DIARRHEA
____DIFFICULTY CONTROLLING BOWEL/BLADDER