

MEDICATIONS

Pill Name:	Pill Dose (mg)	How often?	Pill Name:	Pill Dose (mg)	How often?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

DRUG ALLERGIES

Name of drug	Type of reaction
_____	_____
_____	_____
_____	_____

SURGERIES OR HOSPITALIZATIONS ?

FAMILY HISTORY

Has anyone in your family ever had:	Yes	No	Relationship
Alzheimer's disease (dementia)			
Stroke			
Dystonia/tics			
Mental Illness (depression, substance abuse, etc)			
Parkinson Disease			
Brain aneurysm (brain bleeding)			
Brain tumor			
Epilepsy			
Migraine			
Other: _____			

REVIEW OF SYSTEMS

Please mark any symptoms you have or may have had:

Contitutional:

- Height
 Weight (is this a Gain or Loss)
 Fevers
 Daytime Sleepiness
 Snoring
 Insomnia

Skin: Rash**ENT:**

- Headaches
 Vertigo
 Double Vision
 Visual Loss

Cardiovascular:

- Chest Pain
 Fainting
 Palpitations

Respiratory:

- Cough
 Shortness of Breath

Gastrointestinal:

- Appetite Change
 Bloody or Dark Stools

Genitourinary:

- Urinary Incontinence
 Loss of Sexual Interest

Musculoskeletal:

- Muscle Pain
 Weakness

Neuro/Psych:

- Memory Trouble
 Anxiety/Depression
 Numbness
 Slurred Speech
 Difficulty Swallowing

Heme/Endocrine:

- Anemia
 Swollen Glands/Lymph Nodes

Other (explain):

For Women: Are you pregnant? Y N Do you use birth control? Y N Are you Nursing? Y N
 (Inform the office if you become pregnant!)