CHAUTAUQUA NEUROLOGY
NEW PATIENT HISTORY FORM

Today's Date _____

Name:_____ Age:_____ DOB:_____

1. Past Medical History (Please circle all that apply)

Alcoholism	Headaches	Peripheral Vascular Disease
Anxiety disorder	Stroke-Cardiovascular	Hernia
Atrial fibrillation	Stroke-Neurologic	Memory loss
Bladder dysfunction	High cholesterol	Stroke-Unknown type
Congestive heart failure	Hyperlipidemia	Ulcer
Constipation	Hypertension	Dizziness
COPD	Hypothyroidism	Seizure disorder
Depression	Kidney disease	
Diabetes	Kidney stones	
Eye Exam (date_____)	Mammogram (date_____)	
Gastritis	Migraines	
Gastroenteritis	Myocardial Infarction	
GERD	Osteoporosis	
GI bleed		

OTHER Medical History:

_____

_____

2. Past Surgical History:

Type	Year	Type	Year
AAA	____	Colon resection	____
Amputation	____	Colonoscopy	____
Angioplasty	____	Cosmetic surgery	____
Back surgery	____	Cyst removal	____
Biopsy positive for cancer	____	Hemorrhoid surgery	____
Bladder suspension	____	Hemorrhoidectomy	____
Breast implant/enhancement surgery	____	Hip Replacement L R	____
Breast surgery	____	Hysterectomy	____
Breast tumor removal	____	Knee Replacement L R	____
C-section	____	Mastectomy L R	____
Coronary Artery Bypass Graph	____	Pacemaker implant	____
Cardiac catheterization	____	Prostate surgery	____
Carotid Carotid endarterectomy	____	Removal of kidney stones	___
Carpal tunnel release	____	Vasectomy	____
Cholecystectomy	____	Tubal Ligation	____
Tonsillectomy	_____	Adenoidectomy	____
Brain surgery	_____	Spinal fusion	____

OTHER Surgical History:

_____

_____

_____

3. Pharmacy

Name of Pharmacy: _____

Address of Pharmacy:_____

Phone Number: _____

4. List the name and dose for each prescription:

1_____ 6_____

2_____ 7_____

3_____ 8_____

4_____ 9_____

5_____ 10_____

5. Any drug allergies?

Drug: Reaction:

1_____ _____

2_____ _____

3_____ _____

4_____ _____

6. Have you had any of the following tests?

Test:	Date:	Location:
MRI	_____	_____
CT Scan	_____	_____
Carotid Doppler	_____	_____
EMG	_____	_____
EEG	_____	_____

Please list any OTHER tests:

_____

_____

7. Do you use tobacco? _____ If so, pack(s) per day___, # of years_____

   Do you use alcohol? _____ If yes, how often _____ Amount _____

   Occupation _____ Disabled? _____, since _____

   Are you right handed, left handed, or ambidextrous? _____

   Do you have a valid driver's license? _____

   Height _____Weight _____

   Who Lives with you at home? _____

8. Family History (Please list medical history for each):

Mother:_____ Father:_____

Brother 1:_____ Sister 1:_____

Brother 2:_____ Sister 2:_____

Brother 3:_____ Sister 3:_____

Brother 4:_____ Sister 4:_____

OTHER Family History:

_____

_____

_____ _____

Signature Date