Welcome to Central VA Neurology, PLC. In order to provide you the best medical care, we need to obtain a complete picture of your medical history. We appreciate your effort in completing the following 3 page medical questionnaire.

Name:_____ Today's date:_____
Referring doctor:_____ Age:_____
Family doctor (Primary care physician):_____
Next of kin, and their relationship to you:_____
Are you right-handed, left-handed or ambidextrous?_____
LIST OF **CURRENT MEDICINES**: please include dosages and how often/day.
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
Do you have any **allergies** to medications, X-Ray Dye or Foods?_____
_____

What is the **main problem** for which you are here today and how long have you had this problem?

_____

_____

Have you had any overnight **hospitalizations**? Please list date and reason. Please also include any surgical procedures and psychiatric admissions.

Where: When: Why:

_____

_____

_____

_____

What other major **medical problems** do you have or have had in the past?

_____

_____

_____

**FAMILY HISTORY**:
Please list ages of immediate family members and any medical problems they might have. If a relative is deceased, please list age and cause of death.
**Father**:_____
**Mother**:_____
**If you have children, please list how many boys & girls and their ages**:
_____
_____
**How many brothers and sisters did you have?**
_____
**Grandparents**:_____
Other family members:_____
_____
If not already listed, has anybody else had a history of any of the following? Seizures (epilepsy), strokes, headaches, other neurological problems, psychiatric problems, diabetes, high blood pressure, heart disease, cancer or other problems._____
_____
**SOCIAL HISTORY**:
Are you married?_____Do you work outside of the home and what type of work do you do?_____
**Education**: please give number of years or grades completed:
gradeschool:_____, high school: _____, college:_____, other:_____
Do you currently **smoke**?_____If you have smoked in the past, when did you quit?_____How many packs/day do you smoke (or did smoke)?_____
Do you drink **alcohol**? If yes, how much?_____
**Caffeine** intake: amount of coffee/day:_____,tea/day :_____,soda/day:_____
Do you get regular **exercise** (list type and frequency/week):_____
Do you have any history of addiction to alcohol, prescription or illegal drugs?_____Is there a family history of addiction?_____

**OTHER HEALTHCARE PROFESSIONALS**:
Please list the names of anyone you are currently seeing as well as the reason you are seeing them. Please include other physicians, psychologists, chiropractors, therapists, etc. _____

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**MEDICAL TESTS**:
If you have had any of these, please list why they were obtained and when.
1. **Neurological examination** (by a neurologist)_____
2. **Psychological exam: counseling and/or testing**_____
3. **CT (CAT) scan**_____
4. **MRI/MRA scan**_____
5. **EEG** (brainwave test)_____
6. **Carotid Doppler**_____

7. **Nerve Conduction Velocity Test/EMG** (electrical test of nerves and muscles)._____
PLEASE CIRCLE ANY OF THE FOLLOWING IF YOU HAVE HAD THAT SYMPTOM OR FILL IN THE BLANK.

Recent weight change
Fever
Fatigue
Headaches
Cancer or tumor
Chronic pain
Cholesterol problem

Blurred or double vision
Spells of blindness of either eye

Hearing loss or ringing
Chronic sinus problems
Cochlear implant

Heart trouble
Chest pain or angina
Palpitations
Hypertension
Pacemaker or defibrillator

Chronic cough
Asthma or wheezing

Loss of appetite
Nausea or vomiting
Rectal bleeding or blood in stool
Stomach or duodenal ulcer
Difficulty swallowing

Blood in urine
Kidney stones
Sexual difficulty

Weakness of muscles
Muscle pain or cramps
Neck or back pain
Difficulty walking

Rash or itching

Frequent headaches
Lightheaded or dizzy
Convulsions or seizures
Numbness or tingling
Tremors
Paralysis
Stroke or TIAs
Head injury or loss of consciousness

Hallucinations
Memory loss or confusion
Nervousness
Depression
Insomnia

Thyroid disease
Diabetes
Heat or cold intolerance

Bleeding or bruising tendency
Anemia
Phlebitis or blood clots

Any other medical problem not listed above?_____
_____
_____

FEMALE - # Pregnancies_____
# Miscarriages_____
Date of last menstrual period_____
Are your periods regular?_____
Is there a chance of pregnancy now or in the future?_____
If on birth control, want kind?_____
Have you had a tubal ligation, or your partner a vasectomy?_____