

Patient Name: _____ Male Female Date of Birth: _____

What are you here to see the doctor about today? _____

Have you had any testing? Xrays CT Scan MRI EMG EEG Lab tests

If yes to any of the above, where and when did you have these tests? When? _____

Bellevue Firelands FTMC Fremont Magruder Willard Other _____

PERSONAL HEALTH INFORMATION

Do you smoke/use tobacco? Yes No or Have you quit? _____ How long? _____ # packs/day _____

Do you drink alcohol or use drugs? Never Rarely Occasionally Weekly Daily

Do you drink coffee, cola, or tea with caffeine or energy drinks? Yes No If yes, How much per day? _____

Do you have any allergies: Yes No If yes, please list: _____

Please check all that apply. Do you have or have you had any of the following?

- | | | | |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke / Blood clot | <input type="checkbox"/> Balance problems | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Convulsions / Seizures | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Fainting / dizziness | <input type="checkbox"/> Weakness / Fatigue | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Back injury or pain | <input type="checkbox"/> Arthritis / Joint pain | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Trouble sleeping / excessive snoring | | <input type="checkbox"/> Problems holding urine or bowel movement | |

Please list any other **major illness** that you have: _____

Please list any **surgeries, serious injuries, or hospitalizations** you have had: _____

Please list any **medications, herbs, nutritional supplements** that you take on a regular basis: _____

Women: # of pregnancies ____ # of live births ____ Are you currently taking oral contraceptives or hormonal medications? Yes No

FAMILY HEALTH INFORMATION

Do any of your **blood relatives** (mother, father, sister, brother, grandparents) have a history of any of the diseases listed below?

- | | | | | |
|---|--|---|-------------------------------------|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Other disease: _____ | | | | |

Date: _____ Signature: _____

Thank you for your cooperation in completing this form. This information will help us in evaluating your overall health and treatment.