Advanced Neurologic Associates, Inc.

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MEDICAL HISTORY INFORMATION

Patient Name: Date of Birth: / / Sex: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □Separated □Widow/Widower

Allergies to Medication:

If over 65, have you had pneumonia vaccination:

CURRENT MEDICATIONS

Name of Medication	Dose	How are you taking it?	Who prescribed it

MEDICAL HISTORY

Have you ever been diagnosed with or had any of the following:

Asthma		**Crohn's Disease**		**Hepatitis A**		**Thyroid Disorder**	
Atrial Fibrillation		**CRF**		**Hepatitis B**		**Tuberculosis**	
Anemia		**Depression**		**Hepatitis C**		**Valvular Heart Disease**	
Anxiety		**Diabetes-Type 1**		**Infertility**		**UTI-Recurrent**	
Autoimmune Disorder		**Diabetes-Type 2**		**Kidney Disease**		**Varicose Veins/Phlebitis**	
Biliary Cirrhosis		**Diverticulitis**		**Kidney Stone**		**Abnormal Pap Smear**	
Blood Transfusions		**DVT**		**Liver Disease**		**Breast Disease**	
Brain Tumor		**GI Bleed**		**MI (Heart Attack)**		**Breast Cancer**	
Cerebrovascular Disease		**GERD**		**Neurologic Disorder**		**D E S Exposure**	
Cirrhosis		**Hemochromatosis**		**Osteoarthritis**		**Diabetes-Gestational**	
CVA/Stroke		**Hyperlipidemia**		**Osteoporosis**		**RH Sensitized**	
COPD		**Hypertension**		**PVD**		**TAH**	
Colon Cancer		**Hypothyroidism**		**PUD**		**TAH w/ BSD**	
Coronary Heart Disease		**Hyperthyroidism**		**Rheumatoid Arthritis**		**Uterine Anomaly**	
NONE		**Memory Issues**		**Seizure Disorder**		**OTHER:**	

ADVANCED DIRECTIVES

□ None □ Living Will □ Full Code □ DNR □DNR Comfort Care □ DNR CC Arrest □ Do Not Intubate □ Guardianship □POA

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SURGICAL HISTORY							
Abdominal – Type: _____		Cholecystectomy		Nephrectomy Transplant			
Amputation		Colon Resection		Pacemaker		Anesthesia Problems	
AV Fistula Creation		Craniotomy		Parathyroidectomy		Surgical Complications	
AV Grait		Gastric Bypass		Pneumonectomy		Post-op Delirium	
Aortic Valve Replacement		Hemorrhoidectomy		PTCA		OTHER LIST	
Appendectomy		Hip Replacement		RAF Bypass		Anesthesia Problems	
B A-F Bypass		Interventional Pain Procedures		Rotator Cuff Repair		Surgical Complications	
Back Surgery		Knee Arthroscopy		TAH w/ BSO		Post-op Delirium	
Bilateral Mastectomy		Knee Replacement		TAH			
Breast Surgery		Kyphoplasty		Tonsillectomy			
Bronchoscopy		LA-F Bypass		Tunneled Dialysis			
CABG		Lumpectomy		U P P P			
Carotid Endarterectomy		Mitral Valve Replacement		Urinary Incontinence Surgery			
Carpal Tunnel		Nephrectomy Native		Vertebroplasty			

SOCIAL HISTORY
TOBACCO USE: □ **YES** □ **NO** □ **FORMER** **IF YES, TYPE:** □ **Cigarettes** □ **Chew** □ **Cigar** □ **Pipe** □ **Other** _____
Packs per day: Years Used: Year Quit:
ALCOHOL USE IN PAST YEAR: □ **YES** □ **NO** **IF YES, TYPE:** □ **Beer** □ **Wine** □ **Hard Liquor** □ **Other** _____
AMOUNT: □ Monthly or less □ 2-4 times per month □ 2-3 times per week □ 4 or more times per week **IF YES, HOW MANY PER DAY:** □ 1-2 □ 3-4 □ 5-6 □ 7-9 □ 10 or more **IF YES, HOW OFTEN DID YOU HAVE 6 OR MORE ON ONE OCCASION IN PAST YEAR:** □ Never □ < Monthly □ Monthly □ Weekly □ Daily or almost daily
CAFFEINE USE: □ **YES** □ **NO** **IF YES, TYPE:** □ **Coffee** □ **Soda** □ **Tea** □ **Other** _____ **Frequency:** _____
RECREATIONAL DRUG USE: □ **YES** □ **NO** □ **FORMER** **IF YES, TYPE:** _____ **Year Quit:** _____

FAMILY HISTORY							
Please Enter: **M = Mother, F = Father, S = Sister, B = Brother, O = Other**							
Alive and Well		CVA (Stroke)		Mental Illness			
ADD/ADHD		Depression		Migraines			
Alcoholism		Developmental Delay		Obesity			
Allergies		Diabetes		Osteoarthritis			
Alzheimer's Disease		Eczema		Osteoporosis			
Asthma		Hearing Deficiency		Vascular Disease			
Blood Disease		High Cholesterol		Kidney Disease			
Heart Disease		High Blood Pressure		Seizure Disorder			
Cancer		Irritable Bowel Disease		OTHER			
Type:		Learning Disability					