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Woodlands Neurology Clinic

NEW PATIENT HEALTH HISTORY

Patient Name _____ **Today's Date** _____

Birth Date _____ **Age** _____ **Reason for appointment?** _____

Pharmacy Name & Telephone # _____

How did you find us (referral/internet?)_____

PCP Name & Phone # _____ **Date of last visit** _____

How would you prefer to be contacted for test results or other communications (circle one)

Online portal or telephone call?

NOTE: If you have prior records you would like Dr. Bonds to review, please bring or send them to our office a few days PRIOR to your appointment.

Please give a brief description of the symptoms you are having, including the duration of your symptoms:

_____

_____

_____

_____

_____

_____

Please list any other physicians you have seen for this problem in the past, and what treatment you received:

_____

_____

_____

Please list any prior hospitalizations which you have had, if any, for this problem:

_____

_____

Past Medial History:

Please list ALL medical problems

_____
_____
_____
_____
_____
_____
_____

Past Surgical History

Please list any previous major surgeries and dates of operations:

Type of Surgery	Year of Surgery
_____	_____
_____	_____
_____	_____
_____	_____

Allergies

Please list any drug allergies and any type of allergic reaction that you may have:

Drug	Reaction(s)
_____	_____
_____	_____
_____	_____

Medications - Please list all current medications

Name of medication	Dosage (strength)	Number of times per day	Problem it was prescribed for

Family History:

Are you adopted? Yes or No

What illnesses, if any tend to run in your family? (please list EVEN if your parents are deceased)

	Age	Health Problems
Father	____	_____
Mother	____	_____
Siblings	____	_____
	____	_____
Children	____	_____
	____	_____
	____	_____

Social History

Dominant hand: Right Left Ambidextrous

Education Level-Please indicate the highest grade you have reached: _____

What is your occupation? _____

Average hours of sleep per night_____

Marital Status: Single_____ Married_____ Divorced_____ Widowed _____

Health Habits

	Amount	Frequency
□ Caffeine	_____	_____
□ Tobacco	_____	_____
□ Alcohol	_____	_____
□ Other	_____	_____

If you are 65 or older:

1. have you had a fall in the last year? Yes No
2. **<u>If yes,</u>** how many have you had: 1 or 2 or more.
3. Were you injured by one of these falls? Yes No

Please circle any symptoms that you are experiencing today:

Constitutional: Fever, chills, fatigue

Eyes: Visual disturbance, discharge, pain, redness, photophobia

Ears Nose Mouth Throat: Congestion, dental problem, ear discharge, ear pain, facial swelling, hearing loss, sinus pain, sore throat, ringing

Respiratory: Cough, chest tightness, shortness of breath

Cardiovascular: Chest pain, palpitations (irregular heart beat), swelling in legs or arms

GI: Abdominal pain, blood in stool, constipation, diarrhea, nausea, vomiting

GU: Difficulty urinating, flank pain, frequency, hematuria (blood in urine)

Musculoskeletal: Joint pain, back pain, joint swelling, muscle pain, neck pain, neck stiffness

Neurologic: Memory loss, tremors, numbness or tingling, vertigo, gait problems

Psychiatric: Behavior problem, confusion, dysphoric mood (depression), hallucinations, nervous/anxious

Endocrine: Cold intolerance, heat intolerance, excessive thirst

Hematology/Lymphatic: Swollen lymph nodes, Bruises easily

Skin: rash, wound

Allergic/Immunologic: Environmental allergies, food allergies, immunocompromised

Prescription Agreement

I agree, as a condition of being treated by Dr. Bonds, that I will not fill or refill any prescription prescribed by another physician for the treatment of any neurologic condition that Dr. Bonds is treating me for.

Any violation of this agreement will result in termination of the physician patient relationship.

Patient Name: _____

Patient Signature: _____

Date: _____