Laura Bonds, M.D
129 Vision Park Suite 201
Shenandoah, TX 77384
Office: 936-267-0912
Fax: 936-267-0935

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. **If yes,** 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