NEUROLOGY SUPPLEMENTAL MEDICAL QUESTIONNAIRE

Please list any physicians to whom you’d like us to send a report:

Today’s Date (mm/dd/yyyy): ______/_____/________

Age: ______ Height: ______ Weight: ______

Dominant Hand: [ ] Left [ ] Right

Do you have any diseases or conditions that you’d like checked at this examination?

Are you taking any of the following blood thinners: [ ] Coumadin [ ] Plavix [ ] Aspirin [ ] Others: ______

Please list any medication allergies: ______

Have you ever filed a Work Injury Report with your employer? [ ] Yes [ ] No

Is a lawsuit planned relating to the current medical problem? [ ] Yes [ ] No

Do you use:

Tobacco? [ ] Yes [ ] No How much? ______

Alcohol? [ ] Yes [ ] No How much? ______

Recreational Drugs? [ ] Yes [ ] No What type(s)? ______

Family History:

Father: Age: ______ Condition of health: ______
[ ] Deceased Age at death: ______ Cause of death ______

Mother: Age: ______ Condition of health: ______
[ ] Deceased Age at death: ______ Cause of death ______

Major illnesses in the family: ______

Medications (Taken Regularly):____

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<th>Medication</th>
<th>Dosages</th>
<th>How Often (example—1 tablet in the morning)</th>
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Surgical & Hospitalization History:

Please list any major illnesses, surgeries, or hospitalizations: (Please include approximate year)

________________________________________

________________________________________

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### Supplemental Medical History

Please check any conditions you have or have had in the past:

- [ ] High Blood Pressure
- [ ] Heart Disease
- [ ] High Cholesterol
- [ ] Asthma
- [ ] Bronchitis
- [ ] Emphysema
- [ ] Tuberculosis
- [ ] Pneumonia
- [ ] Appendicitis
- [ ] Liver Disease
- [ ] Ulcers
- [ ] Carpal Tunnel Syndrome
- [ ] Rheumatoid Arthritis
- [ ] Osteoporosis
- [ ] Arm Pain
- [ ] Diabetes
- [ ] Thyroid Disease
- [ ] Stroke
- [ ] Fibromyalgia
- [ ] Neck Pain
- [ ] Neuropathy
- [ ] Sciatica
- [ ] Seizure / Epilepsy
- [ ] Bipolar Disorder
- [ ] Depression
- [ ] Alcohol Problems
- [ ] Eating Disorder
- [ ] Suicide Attempt
- [ ] Chemical Dependency
- [ ] Psychiatric Illness
- [ ] Bleeding Disorders
- [ ] Clotting Disorder
- [ ] Breast Lump
- [ ] Kidney Disease
- [ ] Gout
- [ ] Sexually Transmitted Disease
- [ ] Leprosy
- [ ] AIDS / HIV
- [ ] Prostate Problems
- [ ] Cancer

Other: ____________

### Review of Systems

Please check boxes to indicate if you have any of these problems frequently, or if they have worsened in the last 6 to 12 months:

- [ ] Fatigue
- [ ] Palpitations/Irregular Heart Beat
- [ ] Abdominal Pain
- [ ] Excessive Thirst
- [ ] Balance Difficulty
- [ ] Fever
- [ ] Leg Swelling
- [ ] Heartburn
- [ ] Temperature Intolerance
- [ ] Numbness
- [ ] Loss of Appetite
- [ ] History of Heart Attack
- [ ] Nausea
- [ ] Lactation
- [ ] Weakness
- [ ] Significant Weight Loss
- [ ] Atrial Fibrillation
- [ ] Vomiting
- [ ] Difficulty Urinating
- [ ] Speech Problems
- [ ] Blurred Vision
- [ ] Hearing Loss
- [ ] Blood In Stool
- [ ] Urinary Urgency
- [ ] Tremors
- [ ] Double Vision
- [ ] Ringing in Ears
- [ ] Anxiety
- [ ] Increased Urinary Frequency
- [ ] Dizziness
- [ ] History of Transfusion
- [ ] Shortness of Breath
- [ ] Depression
- [ ] Urinary Incontinence
- [ ] Itching
- [ ] Easy Bruising
- [ ] Sleep Apnea
- [ ] Sleep Disturbances
- [ ] Joint Pain
- [ ] Redness
- [ ] Anemia
- [ ] Cold & Cough
- [ ] Hyperactivity
- [ ] Joint Swelling
- [ ] Rash
- [ ] Chest Pain
- [ ] Change in Voice
- [ ] Attention Deficit
- [ ] Joint Stiffness
- [ ] Muscle Aches
- [ ] Skin Cancer
- [ ] Difficulty Swallowing
- [ ] Excessive Sweating
- [ ] Other: ____________

Patient Signature: X ________________________________ Date: __/__/_______

Official use only: MRN#: __________________ Account #: ________________