A department of Ka'u Hospital
East Hawaii Health Clinic
1190 Waianuenue
Neurology

Patient Name: _____ Birthdate: _____

NEUROLOGY SUPPLEMENTAL MEDICAL QUESTIONAIRE

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)*:

Medication	Dosages	How Often (example—*1 tablet in the morning*)

Surgical & Hospitalization History:

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

_____

_____

_____

_____

_____

Official use only: MRN#: _____ Account #: _____

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NEUROLOGY SUPPLEMENTAL MEDICAL QUESTIONAIRE

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

Patient Signature: *X*_____ Date: _____/ _____/ _____

Official use only: MRN#: _____ Account #: _____