Minneapolis Clinic of Neurology

www.minneapolisclinic.com

HEALTH AND HISTORY

Thank you for filling out this form. The information you provide will facilitate your visit and will be entered into your medical record. Please use either a black or blue ball point pen to fill out the form.

*MCN Provider:*_____

Your Name: _____ **Date of Birth:** _____

Age: _____ **Height:** _____ **Weight:** _____ **Date of Visit:** _____

Handedness (with which hand do you write or throw a ball, for example) **Right / Left / Either**

Name of the doctor who referred you to our clinic: _____

Briefly list the reason(s) for this visit: _____

_____

Medical History: please indicate if you currently have, or have had in the past, any of the following:

CONDITION	YES	(For office use)
Anxiety	☐	_____
Asthma	☐	_____
Black Outs	☐	_____
Blood Clots	☐	_____
Cancer	☐	_____
Depression	☐	_____
Diabetes	☐	_____
Emphysema	☐	_____
Head Injury	☐	_____
Headaches	☐	_____
Heart Disease	☐	_____
High Blood Pressure	☐	_____
High Cholesterol	☐	_____
Kidney Disease	☐	_____
Liver Disease	☐	_____
Memory Problems	☐	_____

PLEASE CONTINUE TO NEXT PAGE

Medical History: please indicate if you currently have, or have had in the past, any of the following conditions (Continued)

CONDITION	YES	(For office use)
Seizures or epilepsy	☐	_____
Sleeping Problems	☐	_____
Stroke	☐	_____
Thyroid Disease	☐	_____
Motor Vehicle Accident	☐	_____
Date of Injury		_____
Work-related Injury	☐	_____
Date of Injury		_____

Any other condition(s) not listed above: _____

Past Surgical History: please list surgeries you have had:

SURGERY	APPROX DATE
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: please list any allergies or reactions you have had to drugs:

_____
_____
_____
_____

Personal History:

Do you use tobacco? Yes Type _____How many packs a day? _____For how many years?_____
No Have you ever smoked? Y / N. If "Yes", when did you quit? _____

Do you drink alcohol? Y / N Approximate daily or weekly amount: _____
Daily caffeine consumption (cups of coffee or cola, for example): _____
Have you ever been on disability? Y / N_____
Do you use street drugs? Y / N _____
Have you ever been treated for chemical dependency? Y / N _____

Marital Status: Married Single Divorced Widowed/Widower Domestic Partner

If You have children how many? _____

Occupation: _____

Education: Please list highest school grade attended_____

PLEASE CONTINUE TO NEXT PAGE

FAMILY HISTORY

Family Members Living?		Present Health	Cause of Death	Age
Father	Y / N			
Mother	Y / N			
Spouse	Y / N			
Brother(s)	Y / N			
Sister(s)	Y / N			
Sons(s)	Y / N			
Daughters(s)	Y / N			

Please Check All Illnesses That Have Occurred In Your Blood Relatives:

	Mother	Father	Sister	Brother	Son	Daughter	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father
Cancer Type										
High blood pressure										
Tremor										
Heart disease										
Migraines										
Diabetes										
Seizure										
Asthma										
Kidney										
Colon										
Stroke										
Osteoporosis										
Parkinson's										
Liver										
High Cholesterol										
Multiple Sclerosis										
Any other disease (s)										

PLEASE CONTINUE TO NEXT PAGE

MY CURRENT MEDICATION LIST:

Name of Prescription and Over the Counter Medications	**Strength (how many mg?)**	**Dosing Schedule/Directions**

Please tell us about the pharmacy where you usually fill your prescriptions. This information may allow us to send prescription and refill information electronically to your pharmacy.

Name: _____ Telephone: _____
Address: _____
City: _____ State: _____ Zip: _____

Review of Symptoms: Please check if you have any problems with:

Stomach/Intestinal/Abdominal Discomfort	☐	Bowel	☐
Balance	☐	Coordination	☐
Dizziness	☐	Weakness/Paralysis	☐
Cardiac	☐	Chest Pain	☐
Hearing Loss	☐	Ringing in Ears	☐
Memory Loss	☐	Numbness/Tingling	☐
Neck Pain	☐	Back Pain	☐
Joint Pain	☐	Arm/Leg Pain	☐
Restless Legs	☐	Movement/Tremor	☐
Speech	☐	Swallowing	☐
Respiratory	☐	Weight Gain or Loss	☐

PLEASE CONTINUE TO NEXT PAGE

(Continued) Review of Symptoms: Please check if you have any problems with:

Skin Changes/Rash	☐	Seizures	☐
Depression	☐	Anxiety	☐
Impotence	☐	Urinary Incontinence	☐
Headaches	☐	Vision	☐
Snoring	☐	Insomnia	☐
Unusual Behaviors/Symptoms during Sleep	☐	Shortness of Breath	☐

Have You Ever Had the Following Tests?

Test	**Yes/No**	**When**	**Where**
CT	Y / N		
EMG	Y / N		
Holter EKG (24 hr.)	Y / N		
MRI	Y / N		
EEG	Y / N		
Spinal tap	Y / N		
Angiogram	Y / N		
Myelogram	Y / N		
Bone Density (DXA)	Y / N		

Immunizations:

	Date	**Type**
Last Influenza Vaccine		
Last Pneumococcal Vaccine		