Health History

Dallas Neuroscience
Guru Motgi, MD

Patient Name:_____ Age:_____ Today's Date:_____

DOB:_____ Reason for Today's Visit:_____

Symptoms (Please check symptoms you currently have or have had in the past year)

GENERAL

O Chills
O Depression
O Dizziness
O Fainting
O Fever
O Forgetfulness
O Headache
O Loss of sleep
O Loss of weight
O Nervousness
O Numbness
O Sweats
O Other

MUSCLE / JOINT / BONE

Pain, weakness, numbnes in:

O Arms
O Back
O Feet
O Hands
O Hips
O Legs
O Neck

GENITO-URINARY

O Blood in urine
O Frequent urination
O Painful urination
O Lack of bladder control

GASTROINTESTINAL

O Poor appetite
O Constipation
O Diarrhea
O Indigestion
O Nausea
O Rectal Bleeding
O Stomach pain
O Vomiting
O Other

HEALTH HABITS

Check which substances you use and describe how much you use.

O Caffine _____
O Tabacco _____
O Drugs _____
O Other _____

CARDIOVASCULAR

O Chest pain
O High blood pressure
O Irregular heart beat
O Poor circulation
O Varicose veins
O Swelling of ankles

EAR / EYE / NOSE / THROAT

O Blurred vision
O Difficulty swallowing
O Double vision
O Loss of hearing
O Nosebleeds
O Persistant cough
O Ringing in ears
O Sinus problems
O Other

SKIN

O Bruise easily
O Itching
O Rash
O Scars

CONDITIONS (Check conditions you currently have or have had in the past year)

O Aids
O Anemia
O Arthritis
O Asthma
O Brest Lump
O Cancer
O Cataracts
O Diabetes
O Epilepsy
O Heart Disease
O Hepatitis
O High Cholesterol
O HIV Positive
O Kidney Disease
O Liver Disease
O Migraines
O Multiple Sclerosis
O Pacemaker
O Psychiatric Care
O Stroke

ALLERGIES

_____
_____
_____

FAMILY HISTORY

List any significant health information about your family

_____
_____
_____
_____
_____

HOSPITALIZATIONS

List any hospitalizations you have had, including the year of the hospitalization, hospital, reason for hospitalization, and the outcome

_____
_____
_____
_____
_____
_____
_____
_____

Pharmacy Name:_____

Pharmacy Phone:_____