Lancaster Neurology

843 W. Meeting St
Lancaster, SC 29720

Personal History Review

Name: ________________________ D.O.B: ______________ Male ❑ Female ❑

Address:____

Phone (H)_____________________ (W)_________________ Cell ____________________

Care Giver Name: ______________________ Phone #________________________

Reason For Visit:____

Current Medication/ Dosag____

____

____

Drug Allergies:

____

Your Past Medical History:

❑ High Blood Pressure	❑ Asthma	❑ Kidney Disease	❑ Depression/Anxiety
❑ Heart Attack	❑ Bleeding Ulcer	❑ Diabetes	❑ Arthritis
❑ Stroke	❑ Hiatal Hernia	❑ Seizure	❑ Memory Disorder
❑ Alcoholism	❑ Cancer	❑ Tremors	❑ Drug Problems
❑ Migraine/ HA	❑ Head Injury	❑ High Cholesterol	❑ Thyroid Condition
❑ Syncope/ LOC	❑ Bleeding Disorder	❑ Pain Symptoms	❑ TB

Any other medical problems? ____

Do you have any metal implants/shards? ❑ Yes ❑ No

Do you have any gun shot wounds? ❑ Yes ❑ No

Are you on any blood thinners? ❑ Yes ❑ No

Do you have a history of kidney disease? ❑ Yes ❑ No

Surgical History:

Have you ever had any surgeries? ❑ Yes or ❑ No

If yes, When:______________________ Procedure:__________________________

When:______________________ Procedure:__________________________

Family History:

❑ High Blood Pressure	Who:______________	❑ Depression	Who:______________
❑ Stroke	Who:______________	❑ Diabetes	Who:______________
❑ Seizure	Who:______________	❑ Cancer	Who:______________
❑ Heart Attack	Who:______________	❑ TB	Who:______________
❑ Bleeding Disorder	Who:______________	❑ Migraine	Who:______________
❑ High Cholesterol	Who:______________	❑ Syncope	Who:______________

Any other medical conditions in the family; please describe ____________________________________

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Social History:

❑ Married ❑ Divorced ❑ Widowed ❑ Single

Children? ❑ Yes or ❑ No How many? ______________

Alcohol use? ❑ Yes or ❑ No How long? _______________ How Much? ______________

Smoker? ❑ Yes or ❑ No How long? _______________ How Many? ______________

If quit, when did you quit? ________________________________

Substance Abuse? ❑ Yes or ❑ No How long? _______________ What? ___________________

If quit, when did you quit? ____

Any history of alcohol or substance abuse rehabilitation? _______________________________________

Occupation: ________________________ Highest Level of Education: __________________________

Personal History Review (cont'd)

General	Now	Past Yr	**Genitourinary**	Now	Past Yr
Fever/ Chills	❑	❑	Painful Urination	❑	❑
Appetite Change	❑	❑	Freq. Urination	❑	❑
Weight Gain	❑	❑	Bladder Control Prob.	❑	❑
Weight Loss	❑	❑	Blood in Urine	❑	❑
Night Sweats	❑	❑	Urinary Infection	❑	❑
Eyes:			**Musculoskeletal**		
Blurred Vision	❑	❑	Joint pain	❑	❑
Double Vision	❑	❑	Back/ neck pain	❑	❑
ENT:			Arm/leg pain	❑	❑
Hearing loss	❑	❑	Muscle pain/cramps	❑	❑
Ringing in ears	❑	❑	**Skin/Breast**		
Sinus trouble	❑	❑	Change in moles/growth	❑	❑
Allergies	❑	❑	Sore that doesn't heal	❑	❑
Nose Bleeds	❑	❑	Breast lumps	❑	❑
Hoarseness	❑	❑	Breast tenderness	❑	❑
Freq Sore throat	❑	❑	Nipple discharge	❑	❑
Mouth Ulcers	❑	❑	**Neurological**		
Cardiovascular			Frequent Headaches	❑	❑
High Blood Pressure	❑	❑	Numbness of arm/leg	❑	❑
Chest Pain	❑	❑	Muscle weakness	❑	❑
Irregular heatbeat	❑	❑	Poor coordination	❑	❑
Fainting/dizzy	❑	❑	Falls	❑	❑
Leg cramps	❑	❑	Tremor/Shaking	❑	❑
Swollen ankles/feet	❑	❑	**Gastrointestinal**		
Pacemaker	❑	❑	Diff swallowing	❑	❑
Respiratory			Diarrhea	❑	❑
Bronchitis/ cough	❑	❑	Heartburn	❑	❑
Coughed blood	❑	❑	Rectal bleeding	❑	❑
wheezing	❑	❑	**Hematology**		
Shortness of breath	❑	❑	Swollen glands	❑	❑
Allergic			Easy bruising/bleeding	❑	❑
Rashes	❑	❑	**Psychiatric**		
Drug Reaction	❑	❑	Depression	❑	❑
Endocrine			Anxiety	❑	❑
Fatigue	❑	❑	Memory Change	❑	❑
Sensitive to hot/cold	❑	❑	Claustrophobia	❑	❑
Change in thirst	❑	❑	Counseling or treatment	❑	❑
Impotence	❑	❑			
Thyroid Swelling	❑	❑			