Alliance Neurology

Neurology Health History Questionnaire

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Dr Wei Tang, M.D.
Dr Avesh Raja Verma, M.D.
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Name: _____ DOB: _____

Occupation: _____ Marital Status: _____

Who referred you to a Neurologist: _____ Name of Primary Care Physician: _____

What condition or symptoms are you being seen for today? _____

_____

_____

_____

What types of testing have you had done for this condition? ☐ MRI ☐ CT ☐ Lab/Blood ☐ Other: _____

When and where did you have the testing? _____

List any problems with the following: _____

Head: _____ Stomach: _____

Eyes, Ears, Nose, Throat: _____ Intestines: _____

Neck or Back: _____ Liver/Gallbladder: _____

Heart: _____ Genitalia: _____

Lungs: _____ Bladder/Kidneys: _____

Bones/Joints: _____ Females: date of last period: _____

Do you Smoke? ☐ No ☐ Yes Packs per day? _____ Age started: _____ Date quit: _____

Do you drink? ☐ No ☐ Yes How much? _____

Family History of Neurological Diseases ☐ No ☐ Yes

Is yes, please explain: _____

_____

Have you had surgery in the last 10 years ☐ No ☐ Yes

Type of surgery: _____ Date: _____ Hospital: _____

Medication Allergies: _____

Daily Medications Including OTC (over the counter): _____

_____

_____