**PACIFIC NORTHWEST NEUROLOGY**
**7502 LAKEWOOD DR, W #C7**
**LAKEWOOD, WA 98499**

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**PATIENT MEDICAL HISTORY** DATE: _____

NAME:_____ SSN:_____

ADDRESS:_____CITY/ZIP:_____

PHONE: (H)_____(C)_____(W)_____

HEIGHT: _____WEIGHT:_____ DATE OF BIRTH:_____

EMPLOYER: _____FULL TIME ( )PART TIME( )RETIRED( )NOT WORKING ( )
STUDENT: FULL TIME ( ) PART TIME ( ) NONE ( )

**SOCIAL:**
MARITAL STATUS_____SPOUSE'S NAME_____

SPOUSE'S DOB: _____

**HEALTH HABITS:**
DO YOU SMOKE? _____ HAVE YOU EVER SMOKED:_____

HOW MUCH _____ HOW MANY YEARS?_____

CAFFEINE INTAKE: COFFEE_____TEA_____COLA_____CUPS/DAY_____
DO YOU DRINK ALCOHOL? _____
HAVE YOU EVER..... FELT NEED TO CUT DOWN ON ALCOHOL? YES NO
ANNOYED BY CRITICISM OF DRINKING? YES NO
HAD GUILTY FEELINGS ABOUT DRINKING? YES NO
TAKEN A MORNING EYE OPENER? YES NO

DO YOU EXERCISE REGULARLY? _____HOW OFTEN_____
DESCRIBE OVERALL HEALTH: GOOD ( ) FAIR ( ) POOR ( )

**REVIEW OF PROBLEMS:** (CIRCLE WHAT APPLIES TO YOU)

**GENERAL:** WT LOSS WT GAIN LOSS OF APPETITE FATIGUE WEAKNESS DEPRESSION HIGH BLOOD PRESSURE
**SLEEP:** INSOMNIA SLEEPINESS
**HEAD:** HEADACHE MEMORY PROBLEMS
**EYES:** VISION CHANGE EYE PAIN
**EARS:** EARACHES HARD WAX TROUBLE HEARING
**NOSE:** CONGESTION NOSE BLEEDS SINUS PROBLEMS
**THROAT:** TROUBLE SWALLOWING SWELLING GOITER
**LUNGS:** COUGH WHEEZING SHORTNESS OF BREATH
**HEART:** CHEST PAIN/PRESSURE IRREGULAR HEARTBEATS
**BREASTS:** LUMP DISCHARGE TENDERNESS
**ABDOMEN:** HEARTBURN ABD. PAIN CONSTIPATION DIARRHEA CHANGE IN STOOLS
**KIDNEY/BLADDER:** BLOOD IN URINE PAIN BURNING LOSS CONTROL
**FEMALES:** DISCHARGE IRREGULAR BLEEDING
**MALES:** DISCHARGE HEMIA IMPOTENCE
**JOINT/MUSCLE:** PAIN STIFFNESS DEFORMITY **WHERE:**_____
**GLAND:** DIABETES THYROID TROUBLE
**OTHER (NOT LISTED):**_____

over →

HEADACHES:

Frequency: _____

Location: _____

Time of the day or night: _____

Duration: _____

HEALTH PREVENTION: (Write in year last done)

| | | |
|---|---|---|
| Tetanus_____ | Flu shot_____ | Pneumonia vaccine _____ |
| TB test _____ | Eye exam _____ | Sigmoidoscopy _____ |
| Rectal exam _____ | PAP smear _____ | Mammogram_____ |
| Chest x-ray_____ | EKG _____ | Cholesterol _____ |

PAST MEDICAL HISTORY: (List operations, injuries and illnesses)

| Problem | Year | Physician or Hospital |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

CURRENT MEDICATIONS:

| NAME | DOSAGE (MGS) | HOW MANY TIMES A DAY | HOW LONG |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

✳ ALLERGIES: ✳

Are you allergic to any drugs or medications? _____

Any side effects to any drugs? _____

Name of drug and describe reaction: _____

_____

FAMILY HISTORY:

Has any family member had (circle all that apply)

| | | | |
|---|---|---|---|
| Diabetes | Heart attack | Breast cancer | Stroke |
| Colon cancer | Seizure (epilepsy) | High blood pressure | |

Put in age or age of death and health for each family member:

| | |
|---|---|
| Father _____ | Mother _____ |
| Brother _____ | Sister _____ |
| Brother _____ | Sister _____ |
| Brother _____ | Sister _____ |
| Child _____ | Child _____ |
| Child _____ | Child _____ |
| Child _____ | Child _____ |

✳ IN CASE OF EMERGENCY, PLEASE NOTIFY: ✳ (Someone who does not live with you)

Name: _____

Relationship: _____

Phone: _____

Address: _____

_____

_____

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