NeurologyPartners, P.C.

Neurology Partners, LLC

Patient History Form

76 Park Street
Attleboro MA 02703
Ph 508.431.2026
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Appointment date:______________________

Name___________________________________
Date of Birth________________________________
Age______
Sex______
Circle one: Married/Single/Div/Sep/Widowed
Place of Birth___________________________
Whom are you living with? _______________
Town of Residence_______________________
Education Level_________________________
Occupation______________________________

Habits- please list amounts and how often
Tobacco_____________________________
Alcohol______________________________
Coffee/Tea/Soda______________________
Street Drugs__________________________

What is the main reason or reasons for this visit?

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Are any of your symptoms related to a work injury or motor vehicle accident? ___________________

Please list medical history including surgeries:

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Please list your medications, include dosages and how you take them

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Please list any allergies

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Please list family history of medical illness

Cancer	High Blood Pressure
Lung disease	Arthritis
Muscle disease	Depression
Headaches	Other Psychiatric Conditions
Allergies	
Heart disease	

Please check any of the following symptoms that you have had in the recent weeks or months:

□ Fever	□ Fatigue
□ Weight changes	□ Excessive sleepiness
□ Dry eyes/ excessive tear production	□ **Blurring of Vision**
□ **Loss of vision**	□ **Eyelid droop**
□ **Loss of smell**	□ Nasal discharge
□ Sinus congestion	□ **Hearing loss**
□ Ear pain	□ **Ringing in the ears**
□ **Facial pain or numbness**	□ **Speech or swallowing problems**
□ Chest pain	□ Palpitations/fluttering of the heart
□ Shortness of breath	□ **Dizziness**
□ Sensitivity to heat or cold	□ Excessive hair loss/thinning
□ Bone loss (eg. Osteoporosis or osteopenia)	□ Joint pain
□ **Neck pain**	□ **Low back pain**
□ **Muscle cramps, pain or weakness**	□ **Numbness or tingling**
□ Frequent infections	□ Depression
□ Anxiety	□ Mood fluctuations
□ Thoughts about harming yourself or others	□ **Balance problems**
□ Bowel issues- change in stool color, bleeding, constipation, diarrhea, stomach pain, excessive gas	□ Bladder issues- frequent urination, difficulty emptying bladder, **loss of bladder control**, infections
□Menstrual irregularities	□ Lack of sex drive/impotence
□ Changes in nail, skin rash, large moles, dry skin	

Please add any additional information not included above:

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Signature____________________________ **Date**_______________________

MD Signature _________________________ **Date**_______________________