MEDICAL HISTORY FORM

NERVEPRO™

NAME:_____

AGE:_____ RACE:_____

CHIEF COMPLAINT TO NEUROLOGIST:_____

DATE SYMPTOMS STARTED:_____ MEDICATION ALLERGIES:_____

PLEASE CHECK THE TESTS YOU HAVE COMPLETED: ☐EEG ☐MRI BRAIN/SPINE ☐PET/CT SCAN ☐EMG/NCV

MEDICATIONS:	DOSE/MG:	FREQUENCY:	START DATE:	REASON USED:
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....

OPERATIONS:	DATE:	MAJOR ILLNESSES:	ONSET:
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

CHECK IF YOU HAVE:

GENERAL
- ☐ FEVER
- ☐ MALAISE
- ☐ WEIGHT GAIN
- ☐ WEIGHT LOSS
- ☐ ANEMIA

EYE
- ☐ EYE PAIN
- ☐ GLAUCOMA
- ☐ BLURRED VISION
- ☐ DOUBLE VISION
- ☐ TEMP LOSS OF VISION

SKIN
- ☐ RASH
- ☐ PSORIASIS
- ☐ MELANOMA
- ☐ ACNE
- ☐ SKIN CANCER

EAR/NOSE/THROAT
- ☐ HEARING LOSS
- ☐ TINNITUS
- ☐ HOARSE VOICE
- ☐ VERTIGO

GENITO URINARY
- ☐ HEMATURIA
- ☐ PROSTATE
- ☐ INCONTINENCE
- ☐ KIDNEY STONES
- ☐ BLADDER INFECTION

CARDIOVASCULAR
- ☐ CHEST PAIN
- ☐ PALPITATION
- ☐ PACEMAKER
- ☐ HEART FAILURE
- ☐ FOOT EDEMA
- ☐ VALVE DISEASE
- ☐ ATRIAL-FIBRILATION

RESPIRATORY
- ☐ ASTHMA
- ☐ SHORTNESS OF BREATH
- ☐ EMPHYSEMA
- ☐ COUGH
- ☐ HEMOPTYSIS
- ☐ SLEEP APNEA

GASTROINTESTINAL
- ☐ HEARTBURN
- ☐ NAUSEA
- ☐ LIVER DISEASE
- ☐ GALL BLADDER
- ☐ SWALLOWING DIFF
- ☐ BLOOD IN STOOL

MUSCLE SKELETAL
- ☐ NECK PAIN
- ☐ BACK PAIN
- ☐ JOINT PAIN
- ☐ CRAMPS
- ☐ CARPAL TUNNEL
- ☐ GAIT TROUBLE
- ☐ JOINT REPLACEMENT

NEUROLOGICAL
- ☐ STROKE
- ☐ SEIZURES
- ☐ MEMORY LOSS
- ☐ SPEECH TROUBLE
- ☐ TREMORS
- ☐ NUMBNESS
- ☐ HEADACHE

LIST ANY FAMILY ILLNESSES:.....

TOBACCO USE:..... PACK/DAY:.....

CAFFEINE:..... SERVING/DAY (COFFEE,COLA,ETC):.....

ALCOHOL USE:..... DRINKS PER DAY/WEEK/MONTH:.....