Diagnostic Neurology
Clinic of Houston

FRONT OFFICE: 713.467.8491

Patient Name: _____ Date: _____

MEDICAL INFORMATION

Chief Complaint (main reason for being here today): _____

_____

Do you have any of the following symptoms? (CHECK ALL THAT APPLY)

___ HEADACHE	___ HEARING LOSS	___ RESTLESS LEGS
___ FACIAL PAIN	___ MEMORY LOSS	___ ABNORMAL MOVEMENTS
___ DIZZINESS	___ CONFUSION	___ FEVER OR CHILLS
___ LOSS OF BALANCE	___ SLEEP DISTURBANCE	___ CHEST PAIN
___ WEAKNESS	___ PASSING OUT	___ SHORTNESS OF BREATH
___ NUMBNESS	___ TREMOR	___ STOMACH / BOWEL PAIN
___ TINGLING	___ STIFFNESS	___ NAUSEA OR VOMITING
___ VISION LOSS OR SPOTS	___ PROBLEMS WALKING	___ INDIGESTION
___ DOUBLE VISION	___ NECK PAIN	___ DIARRHEA
___ SLURRED SPEECH	___ BACK PAIN	___ CONSTIPATION
___ SWALLOWING PROBLEMS	___ ARM PAIN	___ IMPOTENCE
___ DROOLING OR CHOKING	___ LEG PAIN	___ LOSS OF BLADDER CONTROL
___ HOARSENESS	___ MUSCLE CRAMPS	___ FREQUENT URINATION
___ LOSS OF SMELL OR TASTE	___ MUSCLE TWITCHING	___ RASH

Have you had or been diagnosed with any of the following? (CHECK ALL THAT APPLY)

___ STROKE	___ HEAD INJURY	___ HIGH BLOOD PRESSURE
___ TRANSIENT ISCHEMIC ATTACK (TIA)	___ BRAIN SURGERY	___ DIABETES
___ PARKINSON'S DISEASE	___ BRAIN TUMOR	___ ARTHRITIS
___ ALZHEIMER'S DISEASE	___ OTHER CANCER	___ HEART ATTACK / ANGINA
___ SEIZURES / EPILEPSY	(DESCRIBE: _____)	___ IRREGULAR HEARTBEAT
___ MIGRAINE	___ MULTIPLE SCLEROSIS	___ HEART SURGERY
___ TENSION HEADACHE	___ MYASTHENIA GRAVIS	___ CAROTID ARTERY SURGERY
___ SINUS HEADACHE	___ NECK SURGERY	___ KIDNEY DISEASE
___ NEURALGIA	___ BACK SURGERY	___ LIVER DISEASE
___ NEUROPATHY	___ OTHER SURGERY	___ EMPHYSEMA
___ MUSCLE DISEASE	(DESCRIBE: _____)	___ ASTHMA OR BRONCHITIS

ALLERGIES: _____

Headache Patients:

How frequent are your headaches? ___ Rare ___ 1 or 2 per month ___ 1 or 2 per week ___ Daily
What do you take for your headaches? _____
Can you identify anything that triggers your headaches? _____
Are your headaches: Always one side Always both sides ___ Either left or right-sided
How many work or school days per month have you missed due to headaches? _____

Female Patients:

When was your last period? _____ _____ Are your periods regular? Yes No
If no periods: Starting menopause After menopause Hysterectomy Other: ____ _____
Are you pregnant? Yes No Are you trying to become pregnant? Yes No
Do you take birth control pills or other hormones? Yes No If yes, which one? _____

NOTE: The above information is part of the Review of Systems and Past Medical History, and inclusion of this data in the medical record indicates that detailed physician review of the information provided has been performed.