NAME:_____ **Date:**___ / ___ / ____

DOB_____**RIGHT OR LEFT HANDED**: _____**YOUR HEIGHT:** _____**YOUR WEIGHT:** _____

REASON(S) FOR TODAY'S VISIT:

_____

MEDICATION ALLERGIES_____

LIST YOUR CURRENT MEDICATIONS (may attach a list)

MEDICATION NAME	Mg SIZE	DIRECTIONS

HAVE YOU BEEN DIAGNOSED WITH DIABETES? (please circle one) YES NO

HAVE YOU FALLEN IN THE LAST YEAR? _____**YES** _____**NO if yes, how often?**_____

DO YOU USE TOBACCO (MARK ONLY ONE):

____Current, every day smoker ____Current, some days smoker ____Never Smoker

____Heavy tobacco smoker >10/day ____Former smoker

____Light tobacco smoker <10/day ____Smoker, current status unknown ____Unknown if ever smoked

TYPE OF TOBACCO USE:

_____Cigarettes _____Cigars ____Oral _____Pipe _____Snuff _____Second hand smoke ____Other

DO YOU DRINK ALCOHOL (circle):

NO YES, _____days/wk HAVE YOU EVER BEEN A HEAVY DRINKER YES/NO

DO YOU DRINK CAFFEINE (circle): NO YES, _____per day

NAME:_____ **Date:**___ / ___ / ____

WHAT SURGERIES OR PROCEDURES HAVE YOU HAD: (may attach a list)

PROCEDURE / SURGERY	YEAR	PROCEDURE / SURGERY	YEAR

LIST YOUR PERSONAL MEDICAL CONDITIONS AND PAST MEDICAL HISTORY: (may attach a list)

NEUROLOGIC FAMILY HISTORY ❒ **None apply** ❒ **Patient Adopted, no known family history**

❒ Unable to Obtain

(Please mark column with ✓if applies)

	MIGRAINE	SEIZURE	STROKE	TREMOR
Mother				
Father				
Sister				
Sister				
Sister				
Brother				
Brother				
Brother				

NAME:_____ **Date:**___ / ___ / ____

Influenza Vaccination (flu shot):

PROCEDURE	DATE PERFORMED	Facility where your vaccination was given	NEVER PERFORMED
Influenza Vaccination	/ /		

Pneumonia Vaccination:

(Please complete if applies, patients 65 years of age and older)

PROCEDURE	DATE PERFORMED	Facility where your vaccination was given	NEVER PERFORMED
Pneumonia Vaccination	/ /		