USF HEALTH

**USF PHYSICIANS GROUP**
**DEPARTMENT OF NEUROLOGY**

**Date:** _____ **MRN #** _____

**Confidential record: Information contained here will not be released except when you have authorized us to do so.**

Last Name _____ First Name _____

Address _____ City, State, Zip _____

Birthdate _____ Birth Place _____

Home Phone _____ Cell Phone _____

Family or Referring Physician _____ Physician Office # _____

Physician Fax # _____ Physician Address _____

**REASON FOR HEALTH VISIT:**

What symptoms or medical problems are you seeing Doctor today for? _____

**MEDICAL PROBLEMS:**

List all current medical problems and those that have required hospitalization in the past? _____

**SURGICAL HISTORY:**

Please list all previous surgeries? _____

**MEDICATIONS:** Please list <u>all</u> medications, dosages, and frequency of administration:

**NAME ANY DRUGS TO WHICH YOU ARE ALLERGIC:**

**PERSONAL HISTORY**

Occupation: _____

Do you regularly smoke? ☐ Yes ☐ No

If so how much?: _____

Have you ever smoked? ☐ Yes ☐ No

How much alcohol do you drink? _____

Any history of recreational drug use? Yes ☐ No ☐

If so which drugs? _____

**FAMILY HISTORY:**

| | Age | Medical Problems | Deceased - if so from what cause? |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brothers/Sisters: | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***PLEASE CIRCLE IF YOU HAVE ANY OF THE BELOW SYMPTOMS:***

**Constitutional** - fever, weight loss, weight gain, night sweats, nausea

**Eyes** - blurred vision, dry eyes, double vision, loss of vision, pain with eye movement

**Cardiovascular** - heart disease, chest pain, palpitations, swelling of the feet and legs

**Respiratory** - asthma, COPD, difficulty breathing, shortness of breath

**Gastrointestinal** - abdominal pain, diarrhea, constipation, bloody stools

**Genitourinary** - painful urination, blood in the urine, frequent urination, sexual dysfunction

**Musculoskeletal** - joint pain, muscle pain

**Skin** - rashes, bites

**Neurological** - seizures, headaches, dizziness, falls, incoordination, numbness, tingling, back pain, neck pain, weakness, difficulty walking, stroke

**Psychiatric** - depression, anxiety, mood disorders

**Endocrine** - intolerant to heat, cold, thyroid dysfunction

**Hematologic** - easy bruising, bleeding, history of blood transfusions

**Allergy** - seasonal or environmental allergies

**Infectious** - HIV, Hepatitis A B C

Patient Signature: _____ Date: _____

Physician Signature _____ Date: _____