Patient Medical History- Intermountain Neurology Clinic

Jahan Imani, MD- Neurology Specialist

Name:___________________________ Date of Birth:____/____/____ Gender:____M / F_____

Height:_________ Weight: _________ Language:_______________ Race:_________________

What are you being evaluated for today? (Circle) Migraine/ Headaches, Epilepsy, Multiple Sclerosis, Tremors, Parkinson's disease, Neuropathy.

Other please list:____

Do you have an attorney because of your medical problems? __Yes______No____
Why?________________________________ Who? _____________________________________

Do YOU have any of the following Medical Problems?

Heart Problems: __Yes____No____Clarify: ____

High Blood Pressure: __Yes____No___Clarify: _____________________________________

Kidney Problems: __Yes____No____Clarify: _______________________________________

Diabetes or Blood Sugar: __Yes____No____Clarify: __________________________________

Liver Problems: __Yes____No____Clarify: ____

Cancer: __Yes____No____Clarify: ____

Lung or Breathing Problem: __Yes____No____Clarify: ________________________________

GI/ Stomach Problems: __Yes____No____Clarify: ____________________________________

Anxiety: __Yes____No____Clarify: ____

Depression: ___Yes__No___Clarify: ____

Arthritis: __Yes____No____Clarify: ____

Thyroid Problem: __Yes____No____Clarify: _______________________________________

Sexually Transmitted Disease: __Yes__No___Clarify: _________________________________

Other Please List and Clarify: ____

Please list ALL current ***Medications***, ***Strengths***, and the ***Frequency*** you take throughout the day. *Or ATTACH a current List.*

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBING DOCTOR

List Medications that you tried and ***DID NOT*** work. ______________________________________

List DRUG ALLERGIES and REACTION to the Medication:__________________________________

____

Social History

Check or Circle all that apply:

Marital Status: ____ Single ____ Divorced ____ Married ____ Widowed

Do you have any children? YES or NO If yes, How many? ________________________________

Are you a current Smoker? : YES or NO If you are a former smoker when did you quit? _______

Do you use Chewing Tobacco: YES or NO Alcohol: YES or NO How often: _______________

Continue from page two.

Are you currently working? YES or NO, If yes, what type of work?___________________________

Full Time/ Part Time? With/ Without restrictions? Describe:_______________________________

If you are NOT working, when did you STOP and why? ____________________________________

Family History

Please list any medical conditions your **IMMEDIATE** family member has been diagnosed with:

Heart Problems: Yes No Clarify: ____________________

High Blood Pressure: Yes No Clarify: ____________________

Kidney Problems: Yes No Clarify: ____________________

Diabetes or Blood Sugar: Yes No Clarify: ____________________

Liver Problems: Yes No Clarify: ____________________

Cancer: Yes No Clarify: ____________________

Lung or Breathing Problem: Yes No Clarify: ____________________

GI/ Stomach Problems: Yes No Clarify: ____________________

Migraine/ Headaches: Yes No Clarify: ____________________

Bleeding or Blood Disorder: Yes No Clarify: ____________________

Anxiety or Depression: Yes No Clarify: ____________________

Tremor: Yes No Clarify: ____________________

Stroke: Yes No Clarify: ____________________

Multiple Sclerosis: Yes No Clarify: ____________________

Parkinson's Disease: Yes No Clarify: ____________________

Psychiatric Illness: Yes No Clarify: ____________________

Other Please List and Clarify: ____

History of Pain

Fill this section out if it applies to you. If NOT please skip to the next section.

Location of Pain: ____

What words best describe your pain? (Check all that apply)

___ Aching, ____ Burning, ___ Shooting, ___ Throbbing, ___ Sharp, ___ Stabbing, ____ Other, Explain:____

Do you currently have any of the following? (Check all that apply)

___ Numbness ___ Coldness ___ Tightness ___ Tingling ___ Skin Discoloration ___ Weakness
___ Increased Sweating ___ Pins & Needles ___ Muscle Spasms
Other, Explain: ____

Which statement best describes your pain? (Check all that apply)

___ Always present, always at the same intensity

___ Always present, intensity varies

___ Usually present, but I have short periods without pain

___ Often present, but have pain free periods for ___ hours out of my day

___ Often present, but pain free for ___ days out of my week

___ Occasionally present, with pain ___ times per day lasting ___ hours or minutes

___ Rarely present, with pain occurring every few days or weeks

___ Does your pain wake you in the night? Yes or No How often? _______________________

Briefly describe your daily physical activities:____

List any activities you have given up because of your pain:________________________________

List any activities you have noticed increases your pain:__________________________________

When did your pain begin?________________ How did it begin?__________________________

Continue from page four.

___ Accident at work   Explain:____

___ Accident at home Explain: ____

___ Motor vehicle accident Explain: ____

___ Following surgery   Explain: ____

___ Following an illness   Explain: ____

___ Pain just began for no reason   Explain: ____

___ Other   Explain: ____

When did you first see a doctor about your pain? _______________________________________

Have you been given a diagnosis for your pain? Yes/No What diagnosis?____________________

Pain section over

What **TEST** have you had done to evaluate your condition?

___ MRI, What HOSPITAL ________________________ Date preformed? ____________________

___ MRA, What HOSPITAL _______________________ Date preformed? ____________________

___ CT Scan, What HOSPITAL _____________________ Date preformed? ____________________

___ Bone Scan, What HOSPITAL ___________________ Date preformed? ____________________

___ EMG/NCV, What HOSPITAL____________________ Date preformed?____________________

___ Blood Work, What HOSPITAL _________________ Date preformed? ____________________

___ EEG, What HOSPITAL ________________________ Date preformed? ____________________

___ Other____ Date preformed?__________________

General History

Please check all the symptoms you have experienced in the past month.

General; ___ Weakness ___ Lack of appetite ___ Weight loss ___ Chills ___ Night sweats
___ Fever ___ Tiredness ___ Excess appetite ___ Wight gain ___ Difficulty sleeping

Musculoskeletal; ___ Muscle pain ___ Neck pain ___ Back pain ___ Joint pain ___ Pain in legs
___ Shoulder/arm pain ___ Joint stiffness ___ Joint swelling

Neurological and Psychiatric; ___ Seizure ___ Headaches ___ Blackouts ___ Dizziness
___ Double vision ___ Loss of sensation ___ Loss of balance ___ Loss of coordination
___ Problems with memory ___ Paralysis or weakness in limbs ___ Early morning awakening
___ Speech problems ___ Difficulty thinking and problem solving

Surgical History

Check all that apply.

___ Hysterectomy ___Appendix ___ Ankles/Feet Right or Left

___ Hip Surgery/ Replacement Right or Left ___ Elbow Surgery Right or Left

___ Hand/ Wrist Right or Left ___ Bladder Repair/ Surgery

___ Bone Graph ___ Brain Surgery ___ Bowel Obstruction

___ Eye Right, Left, or Both ___ Heart Surgery ___ Thyroid Removal

___ Tonsils ___ Knee Surgery Right or Left

___ Gallbladder Surgery or Removal ___ Shoulder Surgery Right or Left

___ Blood Transfusion ___ Neck Surgery ___ Rhizotomy

___ Face Surgery/Lift ___ Cancer removal Explain: ______________________________

___ Ear Surgery Right, Left, or Both ___ Limb Removal Explain:_____________

___ Other Explain: ____

Genital- Reproductive

Female

Age of onset menstrual period:_________________ Age of onset menopause:______________
How far apart are your periods:_________________ How many days does it last:____________
Is the flow; Heavy, Light, or Normal:__________ What was the date of your last period:__/_/__

Check all that apply

___ Bleed between periods
Explain:_________________

___ History of STD
Explain:_________________

___ Hot Flashes
Explain:_________________

___ Decreased sexual desire
Explain:_________________

___ Vaginal bleeding after Menopause
Explain:___________________________________

Male

Check all that apply

___ Testicular pain
Explain:_________________

___ Decreased sexual desire
Explain:_________________

___ History of STD
Explain:_________________

___ Discharge from penis
Explain:_________________

___ Decrease testicular size
Explain:_________________

___ Cannot achieve Erection
Explain:________________

___ Lumps in testicles or scrotum
Explain:_________________

Any other questions or concerns that you would like to address please list below. Thank you.

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The End.