North Texas Neurological Consultants
Initial Patient History

Name: _____ **Date:** _____

Please check whether or not each condition applies to you.

	Yes	No
Headaches	( )	( )
Seizures	( )	( )
Fainting	( )	( )
Dizziness	( )	( )
Neck pain	( )	( )
Back pain	( )	( )
Problems walking	( )	( )
Problems speaking	( )	( )
Memory problems	( )	( )
Paralysis	( )	( )
Head Injury	( )	( )
Nerve Injury	( )	( )
Loss of vision	( )	( )
Loss of hearing	( )	( )
Loss of consciousness	( )	( )
High blood pressure	( )	( )
Heart problems	( )	( )
Asthma	( )	( )
Other lung problems	( )	( )
Ulcer	( )	( )
Hiatal hernia	( )	( )
Hemorrhoids	( )	( )
Gallstones	( )	( )
Diabetes	( )	( )
Thyroid problems	( )	( )
Depression	( )	( )
Anxiety	( )	( )
Insomnia	( )	( )
Daytime drowsiness	( )	( )
Kidney stones	( )	( )
Loss of bladder control	( )	( )
Cancer	( )	( )

Please check off operations you have had:

Coronary bypass	( )
Lung surgery	( )
Carotid artery	( )
Gallbladder	( )
Appendectomy	( )
Hysterectomy	( )
Tonsillectomy	( )
Groin hernia	( )
Hiatal hernia	( )
Back surgery	( )
Neck surgery	( )
Hip surgery	( )

Please list any other surgery you have had:

Please list all medications that you are current taking: including strength and dosage instructions and how long you have been taking each medication:

Skin problems	( )	( )
Arthritis	( )	( )
Broken bones	( )	( )
Do you smoke?	( )	( )
If so, how much?		
Did you every smoke?	( )	( )
Do you drink alcohol?	( )	( )
If so, how much?		
Alcohol problems?	( )	( )
Drug problems?	( )	( )
Psychiatric problems or Treatment?	( )	( )

Please list disease that run in your family:

Female Patients:

Date of last period _____

Number of pregnancies _____

Number of miscarriages _____

Number of abortions _____

PLEASE LIST ALL DRUG ALLERGIES. IF YOU HAVE NO ALLERGIES TO MEDICATIONS, WRITE "NONE":

PLEASE DESCRIBE THE PROBLEM FOR WHICH YOU ARE SEEING DR. ROSENSTEIN:

_____

Signature **Date**

_____

Print full name

REVIEWED AND DISCUSSED WITH PATIENT

_____

JACOB ROSENSTEIN, M.D. **DATE**

Please indicate the site(s) and type of your pain by marking these drawings with the indicated symbols.

Ex. - If you suffer from numbness in your hands, draw the equal (=) sign on your hands.