NEUROLOGIC CARE ASSOCIATES, P.C.

3340 S. Oak Park Ave Suite 200 Berwyn, IL 60402 708-783-0222

Pertinent Past Medical History Information

Date: _____

Patient Name: _____

Your input regarding your past medical history and description of your current symptoms is a very important part of the process of developing an accurate diagnosis and treatment plan. Please be as complete as possible in answering the following questions.

Have you ever been injured in an accident or other trauma that involved:

	Yes / No	Approximate Date
Head injury / concussion	_____	_____
Neck injury	_____	_____
Back injury	_____	_____
Is there a lawsuit or work comp case pending?	_____	_____

Have you had fainting or blackout spells in the past?

Yes _____ No _____ Roughly how many? _____

Have you had any major surgeries?

Type	Approximate Date
_____	_____
_____	_____
_____	_____

Have you been treated for:

_____ Diabetes	_____ Heart attack	_____ Thyroid disease
_____ High blood pressure	_____ Stroke	_____ Other
_____ High cholesterol	_____ Seizures/Epilepsy	

Please list the medications you are taking on a daily basis.

Name	Dose size and schedules if known
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Are there any family members who have or have had:

	Yes / No	Relation
1. Cancer	_____	_____
2. Diabetes	_____	_____
3. Heart attack (under age 60)	_____	_____
4. Stroke (under age 60)	_____	_____
5. High blood pressure	_____	_____
6. Progressive weakness or other impairment	_____	_____
7. Headaches	_____	_____
8. Seizures	_____	_____
9. Memory loss	_____	_____
10. Multiple Sclerosis		
11. Autoimmune disease (Lupus, Rheumatoid arthritis, etc)	_____	_____
12. Other	_____	_____

Do you have significant allergies to:

	Yes/No	Name
Pollens, dust etc	_____	_____
Medications or x-ray dyes	_____	_____

Do you smoke? No _____ Yes _____ Packs per day _____ # of years _____

Rough estimate of alcohol or drug use _____

Do you exercise on a daily basis? Yes _____ No _____

Usual activities _____

REVIEW OF SYSTEMS: Circle areas you have problems with:

Skin Extremities Ears / Nose / Throat Heart / Lungs

Stomach Bowel / Bladder Other

Please jot down any other comments about your past medical history, or special concerns, facts, or fears about your current problem so that we will be sure to address them during the visit.

_____

_____

_____

Also please try to organize in your mind a description or your most recent symptoms, the time of onset, etc.

Thank you for your help.