Fullerton Neurology and Headache Center

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DATE COMPLETED:	PATIENT:

PAST, FAMILY, SOCIAL HISTORY

PAST HISTORY TREATMENTS. **YOUR PAST EXPERIENCES WITH ILLNESSES, OPERATIONS, INJURIES &**

Medications: **Please list your <u>current</u> medications, including over-the-counter and nutritional supplements:**

Medicine	Dose	How often?	Reason taken
Example: Aspirin	*81 mg*	*Daily*	*Prevent heart attack*

Allergies: **Are you allergic to any medications?**

☐ Yes, please list below: ☐ No

Medicine	Reaction
Example: Sulfa	*Redness and swelling*

Diseases: **Are you currently being treated for any chronic illnesses?**

☐ Yes, please list below: ☐ No

Disease	Physician treating	For how long?

Who is your primary care physician?

Injuries: **Have you recently fallen or had serious injuries resulting from an accident?**

☐ Yes, please explain below: ☐ No

Hospitalizations: **Please list recent hospitalizations or major surgeries, including dates:**

When did you last visit an emergency room and why?

FAMILY HISTORY WHICH **A REVIEW OF THE MEDICAL EVENTS IN YOUR FAMILY, INCLUDING DISEASE(S) MAY BE HEREDITARY.**

Mother: ☐ living Age: Chronic illness(es):
☐ deceased Age: Cause of death:

Father: ☐ living Age: Chronic illness(es):
☐ deceased Age: Cause of death:

Family: **Have any of your immediate relatives been diagnosed with the following illnesses?**

☐ Arthritis	☐ Heart disease	☐ Multiple Sclerosis
☐ Asthma/Lung disease	☐ High blood pressure	☐ Parkinson's disease
☐ Cancer	☐ Kidney disease	☐ Seizures
☐ Dementia/Alzheimer's	☐ Liver disease	☐ Stroke
☐ Diabetes	☐ Migraine headache	☐ Thyroid disease

☐ _____

Additional Information:

SOCIAL HISTORY **A REVIEW OF YOUR PAST AND CURRENT ACTIVITIES.**

Personal: Marital status: ☐ single ☐ married ☐ domestic partner ☐ separated ☐ divorced ☐ widowed ☐ not applicable / minor

Education: Highest grade completed:

Please check the following, if the statement describes you.
- ☐ I sometimes feel depressed.
- ☐ I don't awaken feeling rested.
- ☐ I awaken frequently at night.
- ☐ My appetite has changed.
- ☐ I have gained or lost weight.

Smoking:
☐ Regularly ☐ Occasionally ☐ In the past ☐ Never
How many packs a day? When did you stop?

Alcohol:
☐ Regularly ☐ Occasionally ☐ In the past ☐ Never
How frequently? When did you stop?

"Street" Drugs:
☐ Regularly ☐ Occasionally ☐ In the past ☐ Never
How frequently? When did you stop?
What drug(s)?

Caffeine:
☐ Regularly ☐ Occasionally ☐ Never
How many times a day? Coffee: Tea: Cola:

Exercise:
☐ Regularly ☐ Occasionally ☐ Hardly ever

DO YOU HAVE A LIVING WILL OR HEALTH CARE DIRECTIVE? ☐ Yes ☐ No

REVIEWED BY:
☐ Jack H. Florin MD ☐ Allison Kennedy, MPAP, PA-C

INITIALS: **DATE:**