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# PATIENT'S SELF-HISTORY

This self-history questionnaire will give Dr. Birnbaum as complete a record as possible of your past health experience. It will save time required for the physician to write the details and should result in a better health interview between you and Dr. Birnbaum. Please give answers as completely as possible. Information which you may think is unimportant may actually be of real value for the physician in diagnosing and following your illness.

Name:________________________________________________________D/Birth: ____/______/_______

Right-handed_____________Left-handed____________Marital status: Single/ Married / Divorced / Widowed

How far in school have you gone?_________________________Current Employer_______________________

Date form completed: _____/______/______Current Primary Care Physician:___________________________

## CURRENT HEALTH PROBLEMS

**List the main symptoms that have caused you to seek neurological consultation:**

1. ______________________________________________
2. ______________________________________________
3. ______________________________________________
4. ______________________________________________
5. ______________________________________________

## OPERATIONS

| Year | Operation | Surgeon | Facility | Complications if any |
|---|---|---|---|---|
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## ACCIDENTS (Especially if to head, neck or back)

| Year | Type of Injury | Treating Doctor | Residual Problems if any |
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## MEDICAL ILLNESSES

If you have had any of the diseases listed, please indicate by a check mark and give the age at which you had the disease along with any complications of the problem.

| | DISEASE | AGE | COMPLICATIONS IF ANY |
|---|---|---|---|
| | Cancer, lymphoma, leukemia | | |
| | Bloodclots in legs | | |
| | Bloodclots in lungs | | |
| | Hepatitis A B C | | |
| | High Blood Pressure | | |
| | Angina (cardiac chest pain) | | |
| | Heart attack | | |
| | Diabetes mellitus | | |
| | Thyroid disorders | | |
| | Asthma | | |
| | Valley Fever or other fungal | | |
| | Pneumonia | | |
| | Tuberculosis | | |
| | Syphilis/gonorrhea | | |
| | Arthritis (specify type) | | |
| | Fibromyalgia | | |
| | Glaucoma | | |
| | Other major medical problem | | |
| | Epilepsy (seizures) | | |
| | Stroke (CVA) | | |
| | Chronic headaches or migraine | | |
| | Pinched nerves | | |
| | Dizziness or balance loss | | |
| | Other neurologic problems | | |
| | Psychiatric care | | |

## MILITARY EXPERIENCE

From____________to ____________What Branch? ______________Rank at discharge_____________________
Service-connected injuries or illnesses_____________________________________________________
Medical discharge?_______________SC-Disability:___________Honorable________Other________________

## FAMILY

Number of children__________Health problems spouse or children_______________________________________
_____________________________________________________________________________________________

## PERSONAL HABITS

**Tobacco**: **No / Yes** Type__________________Amount per day__________________________________________
**Alcohol: No / Yes** Beer__________________Amount per day_________________________________________
Wine__________________Amount per day__________________________________________
Liquor_________________Amount per day__________________________________________

## CURRENT MEDICATIONS

| Name of Drug | Strength | Dosing | Name of Drug | Strength | Dosing |
|---|---|---|---|---|---|
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**Other medications taken during last two years:** ____________________________________________

____________________________________________________________________________

**DRUG ALLERGIES No / Yes Drug:** ______________________________________________________

**Are you sensitive to iodine preparations? No / Yes** Reaction type: ______________________________

Do you have any other allergies?_________________________________________________________

**DO YOU HAVE ANY BLEEDING TENDENCIES?: No / Yes Type:** ___________________________

**IF FEMALE, DO YOU BELIEVE YOU MIGHT BE PREGNANT? No / Yes / Unsure**

## FAMILY HISTORY

| Relative (biological relatives only) | Living or Deceased | Present age or Age at Death | Current Health Status if Living Including any Major Problems | Cause of Death If Now Deceased |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| | | | | |
| | | | | |
| Sisters | | | | |
| | | | | |
| | | | | |

If there have been any diseases or disorder that seem particularly common in your family, indicate them here:

____________________________________________________________________________

If any of the following problems have affected family members, please indicate whether father, mother, etc:

Cancer ______________________ Epilepsy___________________ Tuberculosis____________________
Hypertension____________________________Diabetes________________________________________
Alcoholism______________________________Nervous or Mental_________________________________

## REVIEW OF SYSTEMS

**Circle symptom ONLY if these has been a recently active or unresolved problem**. Add any details you consider important, including if care already sought, treatment already provided, etc.

- Forgetfulness
- Wrong use of words
- Speech problems
- Difficulty reading
- Changes in personality
- Excessive restlessness
- Periods of confusion
- Depression
- Anxiety
- Excessive crying
- Hallucinations
- Explosive temper
- Personality change
- Change in sense of taste
- Swallowing problems
- Persistent voice hoarseness
- Persistent hiccups
- Numbness or tingling
- Weakness
- Muscle cramps
- Muscle twitching
- Muscle shrinkage
- Loss of coordination
- Tremors
- Involuntary movements
- Walking problems
- Neck pain or stiffness
- Back pain or stiffness
- Arm or hand pain

- Leg or foot pain
- Facial pain
- Eye pain
- Double vision
- Loss of side vision
- Failing vision
- Use of glasses or contacts
- Earaches
- Pain behind ear
- Noises in ear
- Hearing Loss
- Ringing in ears
- Dizziness
- Nosebleeds
- Loss of sense of smell
- Nasal discharge
- Decayed teeth or toothache
- Bleeding gums
- Sore tongue
- Chewing difficulty
- Difficulty swallowing
- Heat or cold intolerance
- Chest pain
- Sudden changes in heart rate
- Shortness of breath
- Persistent cough
- Productive cough
- Wheezing
- Difficulty breathing lying down

- Fever, sweats or chills
- Swollen legs or feet
- Swollen abdomen
- Excessive gas
- Nausea
- Vomiting
- Vomiting of blood
- Abdominal pain
- Ulcer disease
- Heartburn or reflux
- Bleeding with stools
- Constipation
- Frequent diarrhea
- Pain with bowel movements
- Difficulty urinating
- Pain with urination
- Frequent urination
- Blood in urine
- Loss of urinary control
- Wetting the bed
- Frequent awakening to urinate
- Swollen lymph nodes
- Skin cancer
- Psoriasis
- Eczema
- Skin infection
- Other skin disorders
- Positive HIV test (please mention to doctor but do NOT circle)