Medical Record Number _____

RANCHO MEMORY CLINIC
RANCHO LOS AMIGOS REHABILITATION HOSPITAL

Health History Form

DATE: _____

NAME: _____ **AGE**: _____

OCCUPATION: _____ **EDUCATION:** _____

HANDEDNESS: RIGHT _____ LEFT _____

WHO REFERRED YOU TO OUR NEUROLOGY CLINIC?

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

CHIEF COMPLAINT: (Describe the reason you are being seen. If you experienced an injury, please describe how it happened):

PAST MEDICAL HISTORY: (Describe any medical problems you have had in the past or currently have, and the year they were diagnosed):

PAST SURGICAL HISTORY: (Please list all surgeries you have had in the past. List appropriate date, type of surgery, hospital name and doctor's name).

NAME: _____

ALLERGIES:

Are you allergic to any medications? Yes _____ No _____
If yes, please name

_____

_____

_____

SOCIAL HISTORY:

Do you smoke: Yes _____ No _____

If yes, how much? _____

Do you drink alcoholic beverages? Yes _____ No _____

If yes, how often? _____

Do you use “recreational” drugs? Yes _____ No _____

CURRENT MEDICATIONS:

NAME	**DOSAGE (#MG)**	**DIRECTIONS (Frequency)**

HAVE YOU HAD	**DATE PERFORMED**	**LOCATION PERFORMED**
X-Rays		
MRI		
CT Scan		
EMG		
Myelogram		
Bone Scan		

NAME OF PATIENT: _____

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING AND DATES:

		Approx date			Approx date			Approx date
[ ]	Heart trouble	___/___/___	[ ]	Thyroid disease	___/___/___	[ ]	Blood clots	___/___/___
[ ]	High blood pressure	___/___/___	[ ]	Migraine	___/___/___	[ ]	Elevated cholesterol	___/___/___
[ ]	Asthma	___/___/___	[ ]	Hepatitis	___/___/___	[ ]	Ulcer	___/___/___
[ ]	Emphysema	___/___/___	[ ]	Liver Disease	___/___/___	[ ]	Colitis	___/___/___
[ ]	TB	___/___/___	[ ]	Gall stones	___/___/___	[ ]	Bone disease	___/___/___
[ ]	Pneumonia	___/___/___	[ ]	Kidney disease	___/___/___	[ ]	Back pain	___/___/___
[ ]	Pleurisy	___/___/___	[ ]	Kidney stones	___/___/___	[ ]	Neck pain	___/___/___
[ ]	Other lung disease	___/___/___	[ ]	Gout	___/___/___	[ ]	Eye problems	___/___/___
[ ]	Diabetes	___/___/___	[ ]	Arthritis	___/___/___	[ ]	Ear problems	___/___/___
[ ]	Blood transfusion	___/___/___	[ ]	Mental illness	___/___/___	[ ]	Venereal disease	___/___/___
[ ]	Cancer	___/___/___	[ ]	Tropical disease	___/___/___			

SYSTEM REVIEW

GENERAL

[ ] Recent weight gain/ amount
[ ] Recent weight loss/ amount
[ ] Fatigue
[ ] Weakness
[ ] Fever

NERVOUS SYSTEM

[ ] Headaches
[ ] Dizziness
[ ] Fainting
[ ] Muscle spasms
[ ] Loss of consciousness
[ ] Sensitivity or pain of hands and/or feet
[ ] Face numbness or tingling
[ ] Muscle weakness
[ ] Muscle tenderness
[ ] Walking difficulty

EARS

[ ] Ringing in ears
[ ] Loss of hearing

EYES

[ ] Pain
[ ] Loss of Vision
[ ] Double or blurred vision
[ ] Dryness
[ ] Feels like something in the eye
[ ] Redness

MOUTH

[ ] Sore tongue
[ ] Bleeding gums
[ ] Sore in mouth
[ ] Loss of taste
[ ] Dryness

THROAT

[ ] Frequent sore throats
[ ] Hoarseness
[ ] Difficulty in swallowing

NECK

[ ] Swollen glands
[ ] Tender glands

HEART & LUNGS

[ ] Pain in chest
[ ] Irregular heart beat
[ ] Sudden changes in heart beat
[ ] Shortness of breath
[ ] Difficulty in breathing at night
[ ] Swollen legs or feet
[ ] High blood pressure
[ ] Heart murmurs
[ ] Cough
[ ] Coughing up blood
[ ] Wheezing
[ ] Night sweats

STOMACH & INTESTINES

[ ] Nausea
[ ] Vomiting of blood or coffee ground material
[ ] Stomach pain relieved by food or milk
[ ] Yellow Jaundice
[ ] Increasing constipation
[ ] Persistent diarrhea
[ ] Blood in stools
[ ] Black stools
[ ] Heartburn

KIDNEY/URINE/BLADDER

[ ] Difficult urination
[ ] Pain or bumming on urination
[ ] Blood in urine
[ ] Cloudy "smoky" urine
[ ] Pus in urine
[ ] Discharge from penis/vagina
[ ] Frequent urination
[ ] Getting up at night to pass urine
[ ] Vaginal dryness
[ ] Rash/ulcers
[ ] Sexual difficulties
[ ] Prostate trouble

PSYCHOLOGY

[ ] Sad/depressed
[ ] Happy/anxious
[ ] Repetitive behavior/habits

ENDOCRINE

[ ] Excessive thirst/hunger
[ ] Nipples discharge

SKIN

[ ] Easy bruising/amount
[ ] Redness
[ ] Rash
[ ] Hives
[ ] Sun Sensitive
[ ] Tightness
[ ] Hair loss
[ ] Nodules/bumps
[ ] Color Changes of hand or feet from the cold

JOINTS/BONES

[ ] Morning stiffness
Lasting how long?
____Hrs ____Min
[ ] Joint pain
[ ] Joint swelling

BLOOD

[ ] Anemia
[ ] Bleeding tendency

NOSE

[ ] Nosebleeds
[ ] Loss of smell
[ ] Dryness

WEIGHT

Has your weight increased, decreased or remained the same in the past 2 years?
[ ] Yes [ ] No
[ ] If no, _____

I have reviewed and confirmed all the information listed above on this page.

_____
Physician's name (Please Print)

_____
Physician's Signature

_____
Date

NAME: _____

FAMILY HISTORY

	If Living		If Deceased,	
	Age	Health (describe any major illness)	Age:	Cause
Mother				
Father				
Sisters				
Brothers				
Children				