RANCHO MEMORY CLINIC RANCHO LOS AMIGOS REHABILITATION HOSPITAL

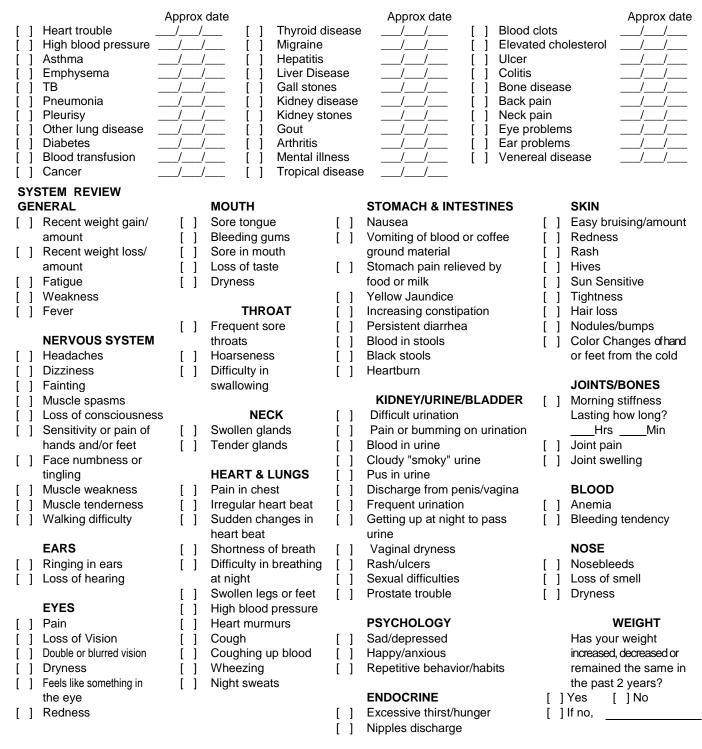
Health History Form

DATE:								
NAME:			AGE:					
OCCUPATION:			EDUCATION:					
HANDEDNESS:	RIGHT	LEFT	_					
WHO REFERRED	YOU TO OUR N	IEUROLOGY 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 If yes, please name	? Yes	No	·
SOCIAL HISTORY:			
Do you smoke: Yes If yes, how much?	No		
Do you drink alcoholic beverages? If yes, how often?	Yes	No	
Do you use "recreational" drugs?	Yes	No	
CURRENT MEDICATIONS:			
NAME	DOSAGE (#MG)	DIRECTIONS (Frequency)
HAVE YOU HAD	DATE PERFOR	MED	
X-Rays			
MRI CT Scan			
EMG			
Myelogram			
Bone Scan			

2 of 4

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



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

Physician's name (Please Print)

Physician's Signature

NAME:

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