SOUTHEASTERN Neurology & MEMORY CLINIC
A Lexington Medical Center Physician Practice

Lexington Medical Park 2
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SENeurologyandMemory.com

Lexington Medical Center

Patient History

Today's Date: _____ Patient Name: _____

Date of Birth:_____ Gender: ☐ Male ☐ Female Race: _____ ☐ Right Handed ☐ Left Handed

Person completing form:_____

Relationship to Patient: _____

Best contact telephone number: Day: _____ Evening: _____

Email (optional): _____

Referring Physician: _____Phone:_____

Address: _____

Primary Care Physician: _____Phone:_____

Address: _____

Main problems and areas of concern	**Onset** (age or date)
1.	
2.	
3.	
4.	

PAST MEDICAL HISTORY (Please check the appropriate answer)

Diagnosis	Yes	No	Year	Diagnosis	Yes	No	Year
Anxiety Disorder	☐	☐		Hypertension (High Blood pressure)	☐	☐	
Asthma	☐	☐		Mood/Bipolar Disorder	☐	☐	
Balance Problem	☐	☐		Numbness/Pain	☐	☐	
Bipolar Disorder	☐	☐		Parkinsonism	☐	☐	
Cancer	☐	☐		PTSD (Post Traumatic Stress Disorder)	☐	☐	
Cholesterol Problems	☐	☐		Restless Leg	☐	☐	
CVA (Stroke)	☐	☐		Seizure Disorder	☐	☐	
Depression	☐	☐		Skin Problems	☐	☐	
Diabetes	☐	☐		Sleep Apnea	☐	☐	
Eating Disorder	☐	☐		Other Sleep Disorders	☐	☐	
Emphysema	☐	☐		Stomach/Bowel Problems	☐	☐	
Fibromyalgia	☐	☐		Tremors	☐	☐	
Head Injury	☐	☐		Weight Loss	☐	☐	
Heart Attack	☐	☐		Thyroid Disorder	☐	☐	
Heart Disease	☐	☐					

GENERAL	Yes	No	GENITOURINARY	Yes	No
Weight Change	☐	☐	Urinary Pain	☐	☐
Appetite Change	☐	☐	Change in Urinary System	☐	☐
Energy Level Change	☐	☐			
HEENT	**Yes**	**No**	**GYNECOLOGICAL**	**Yes**	**No**
Headaches	☐	☐	Last menstrual Period (Date):_____	☐	☐
Eyes	☐	☐	Hysterectomy	☐	☐
Ears	☐	☐	Number of Pregnancies: _____	☐	☐
Nose	☐	☐	Number of Children: _____	☐	☐
Throat	☐	☐	Vaginal Discharge	☐	☐
NECK	**Yes**	**No**	**NEUROLOGICAL**	**Yes**	**No**
Swelling	☐	☐	Weakness in Arms/Legs	☐	☐
Tenderness	☐	☐	Dizziness/Fainting	☐	☐
Goiter	☐	☐	Stroke/TIA	☐	☐
CHEST	**Yes**	**No**	**EXTREMITIES**	**Yes**	**No**
Pain	☐	☐	Swelling of Hands/Feet	☐	☐
Pressure	☐	☐	Varicose Veins	☐	☐
Racing Heart (Palpitations)	☐	☐	Leg Cramps	☐	☐
BREASTS	**Yes**	**No**	**SKIN**	**Yes**	**No**
Tenderness	☐	☐	Rashes	☐	☐
Lumps	☐	☐	History of Skin Cancer	☐	☐
LUNGS	**Yes**	**No**	**MUSCULOSKELETAL**	**Yes**	**No**
Chronic Cough	☐	☐	Joint Pain or Swelling	☐	☐
Shortness of Breath	☐	☐	Rheumatoid Arthritis	☐	☐
Blood in Sputum	☐	☐	Low Back Pain	☐	☐
DIGESTIVE SYSTEM	**Yes**	**No**	**PSYCHOLOGICAL**	**Yes**	**No**
Abdominal Pain	☐	☐	Depression	☐	☐
Nausea	☐	☐	Anxiety	☐	☐
Change in Bowel Habits	☐	☐	Sexual Difficulties	☐	☐
Black Tarry Stool	☐	☐	Abuse by Spouse or Other	☐	☐
Red Blood in Stool	☐	☐	Alcohol or Drug Addiction	☐	☐
OTHER PROBLEMS	**Yes**	**No**	Other:		

SURGICAL PROCEDURES		
Type of Surgery	**Year**	**Comments**

SOCIAL AND OCCUPATIONAL HISTORY

Hand dominance: ☐ Right ☐ Left Ambidextrous (both): ☐ Yes ☐ No

Major Employment or occupation(s): _____

Homemaker? ☐ Yes ☐ No Retired? ☐ Yes ☐ No

Number of years education completed: _____ Type of Degree: _____

EMPLOYMENT	YEARS

Disability Status (if applicable): _____

Military Experience: ☐ Yes ☐ No If so, number of years: _____

Hobbies: _____

_____

Artistic Interests (Music, painting, writing, crafts): _____

_____

Smoking/Tobacco Use: ☐ Yes ☐ No Formerly: _____ Year Quit: _____

Type of Tobacco Product: _____

Units/packs per day: _____ Number of Years: _____

Alcohol Use: ☐ Yes ☐ No Formerly: _____ Year Quit: _____

Type of Alcohol: _____ Frequency: _____ Amount per Day: _____

History of DUI(s): ☐ Yes ☐ No 12-Step Groups? ☐ Yes ☐ No

Current or previous substance use: Marijuana: ☐ Yes ☐ No Cocaine: ☐ Yes ☐ No Other: _____

Toxic Environmental or Occupational Exposures: _____

SUBSTANCE(S), CIRCUMSTANCES	TIME	PROTECTIVE GEAR?

Wood, Gas, or Oil Heat: ☐ Yes ☐ No CO Monitor used: ☐ Yes ☐ No

ADVANCED DIRECTIVES: (please check the appropriate response)

Living will: ☐ Yes ☐ No
Do not place on life support: ☐ Yes ☐ No
Health Care Proxy: ☐ Yes ☐ No
DNR (do not resuscitate): ☐ Yes ☐ No
Durable power of attorney: ☐ Yes ☐ No

MEDICATION / ALLERGIES

Medications: Please list all medications currently taken, amounts, and time taken.
(Include all injections, inhalers, eye medications, vitamins/supplements)

Medication Name	MG	Dose	How Often?
Injections	MG	Dose	How Often?
Inhalers	MG	Dose	How Often?
Vitamins / Supplements	MG	Dose	How Often?

Allergies / Drug / Medication	Reaction	Year
Foods / Other Allergies	Reaction	Year

FAMILY HISTORY

PARENTS (Enter information, but no names)

Patient adopted? ☐ Yes ☐ No Information about parents not available? ☐ Yes ☐ No

PATIENT'S FATHER/MOTHER (check appropriate box for father or mother)

Memory problems or dementia (describe): _____

_____

Cholesterol problems:	☐ Father	☐ Mother	Thyroid disorder:	☐ Father	☐ Mother
Heart Disease:	☐ Father	☐ Mother	Bipolar disorder:	☐ Father	☐ Mother
Asthma/emphysema:	☐ Father	☐ Mother	Diabetes:	☐ Father	☐ Mother
Anxiety Disorder:	☐ Father	☐ Mother	Parkinsonism:	☐ Father	☐ Mother
Sleep Disorder:	☐ Father	☐ Mother	Cancer:	☐ Father	☐ Mother
High Blood Pressure:	☐ Father	☐ Mother	Depression:	☐ Father	☐ Mother
Stroke:	☐ Father	☐ Mother			

PATIENT'S SIBLINGS (check appropriate box for brother or sister)

Memory problems or dementia (describe): _____

_____

Cholesterol problems:	☐ Brother	☐ Sister	Thyroid disorder:	☐ Brother	☐ Sister
Heart Disease:	☐ Brother	☐ Sister	Bipolar disorder:	☐ Brother	☐ Sister
Asthma/emphysema:	☐ Brother	☐ Sister	Diabetes:	☐ Brother	☐ Sister
Anxiety Disorder:	☐ Brother	☐ Sister	Parkinsonism:	☐ Brother	☐ Sister
Sleep Disorder:	☐ Brother	☐ Sister	Cancer:	☐ Brother	☐ Sister
High Blood Pressure:	☐ Brother	☐ Sister	Depression:	☐ Brother	☐ Sister
Stroke:	☐ Brother	☐ Sister			

PATIENT'S CHILDREN (check appropriate box for son or daughter)

Number of sons: _____ Number of daughters: _____

Memory problems or dementia (describe): _____

_____

Cholesterol problems:	☐ Son	☐ Daughter	Thyroid disorder:	☐ Son	☐ Daughter
Heart Disease:	☐ Son	☐ Daughter	Bipolar disorder:	☐ Son	☐ Daughter
Asthma/emphysema:	☐ Son	☐ Daughter	Diabetes:	☐ Son	☐ Daughter
Anxiety Disorder:	☐ Son	☐ Daughter	Parkinsonism:	☐ Son	☐ Daughter
Sleep Disorder:	☐ Son	☐ Daughter	Cancer:	☐ Son	☐ Daughter
High Blood Pressure:	☐ Son	☐ Daughter	Depression:	☐ Son	☐ Daughter
Stroke:	☐ Son	☐ Daughter			