DEPARTMENT OF NEUROLOGY
HEALTH ASSESSMENT FORM

Name___________________________________ Date_______________________

Date of Birth______________________________ Phone(home)______________________________

Address___________________________________ Phone (work)_____________________________

____ Phone (cell)______________________________

____ Email____________________________________

Medical Record # (office to complete): Person completing this form:

____ ____

Who is your Primary Care Physician? **Who suggested you consult a Neurologist?**

____ Physician(Name)_________________________

Address___________________________________ Other____________________________________

____

Phone # __________________________________ Last visit to Physician_________________________________

Is your care related to a Bureau of Worker's Compensation (BWC) case? ☐ Yes ☐ No

If yes: BWC Case #________________________ Case Manager_____________________________

Is there a lawsuit pending concerning your medical condition? ☐Yes ☐ No

What is the problem for which you are being seen (chief complaint)?

What tests have been done?

Have you seen other doctors for this problem (please list)?

11100 Euclid Avenue Cleveland, OH 44106-5040
http://casemed.case.edu/dept/neurology

PAST MEDICAL HISTORY: Please list all medical problems and surgeries you have had (including cataract surgery, biopsies, and skin procedures).

Active Medical Problems	Old Medical Problems	Surgeries (dates)

MEDICINES: Please list all medicines (prescription, non-prescription, alternative/supplements/ vitamins, birth control tablets, etc.), the dose you take and how often.

____
____
____
____
____
____
____
____
____

ALLERGIES: Please list any medication allergies

____
____

SOCIAL HISTORY

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children?: ☐ Yes ☐ No

If yes, how many and how old:______________________________

Are you presently employed?: ☐ Yes ☐ No Grade level of education (last year completed)___________

Occupation (s):____

Year of retirement (if applicable)_________________ Year disabled (if applicable)_______________

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Name___________________________________ Date_______________________

Do you smoke? ☐ Never Used ☐ Yes ☐ Quit If quit: when:_____________________

When did you first start smoking:____________ How much per day do or did you smoke?____________

Do you drink Alcohol / Wine / Beer? ☐ Never Used ☐ Yes ☐ Quit If quit: when:___________

If yes, how often? ☐ Daily ☐ More than 3 times per week ☐ Less than 3 times per week

If yes, how much?____

Have you used recreational drugs? ☐ No ☐ Yes

If yes, what drugs and when:____

Do you regularly exercise? ☐ No ☐ Yes

If yes, what type and how often:____

Are you on any type of special diet? ☐ No ☐ Yes

If yes, what type:____

FAMILY HISTORY

Please list any major medical problems in your relatives (especially any neurologic conditions, diabetes, heart disease, high blood pressure and cancer):

Mother:____

Father:____

Brothers/Sisters:____

Your children (if applicable):____

____

Are there any other important medical conditions in other relatives? Is yes, please list: ________________

____

REVIEW OF SYSTEMS: Please CHECK if you have any of these symptoms currently.

Constitutional (1)
- ☐ Fever / Chills / Sweats
- ☐ Weight Loss
- ☐ Tiredness / Fatigue
- ☐ Poor Appetite

Eyes (2)
- ☐ Reduced vision or blurriness
- ☐ Double vision
- ☐ Droopy eye lids
- ☐ Cataracts
- ☐ Glaucoma

Ears / Mouth / Nose / Throat (3)
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Vertigo
- ☐ Hoarseness
- ☐ Sinus pain
- ☐ Swallowing problem

Cardiovascular (4)
- ☐ Chest pain / Angina
- ☐ Palpitations
- ☐ Shortness of breath lying flat
- ☐ Pain in the legs with walking
- ☐ Phlebitis
- ☐ Heart attack
- ☐ High blood pressure
- ☐ High cholesterol / lipids

Respiratory (5)
- ☐ Cough
- ☐ Phlegm
- ☐ Coughing up blood
- ☐ Wheezing / Asthma

Gastrointestinal (6)
- ☐ Abdominal pain
- ☐ Nausea and / or vomiting
- ☐ Vomiting up blood
- ☐ Change in bowel movements
- ☐ Diarrhea
- ☐ Constipation

Genitourinary (7)
- ☐ Pain with urination
- ☐ Excessive urination
- ☐ Incontinence
- ☐ Blood in the urine
- ☐ Sexual problems
- ☐ Prostate problems

Musculoskeletal (8)
- ☐ Neck or back pain
- ☐ Muscle pain
- ☐ Pain / redness / swelling of a joint

Skin (9)
- ☐ Rash
- ☐ Change in sweating
- ☐ Burns

Neurologic (10)
- ☐ Headache
- ☐ Numbness or Tingling
- ☐ Muscle weakness
- ☐ Loss of consciousness
- ☐ Memory or thinking problems
- ☐ Trouble with walking or balance
- ☐ Stroke
- ☐ Seizure

Psychiatric (11)
- ☐ Psychological or Psychiatric care
- ☐ Depression
- ☐ Hallucinations
- ☐ Anxiety
- ☐ Suicidal thoughts

Endocrine (12)
- ☐ Hot / cold intolerance
- ☐ Thyroid problems
- ☐ Diabetes or sugar problem

Hematologic / Lymphatic (13)
- ☐ Anemia
- ☐ Easy bruising
- ☐ Enlarged lymph nodes

Allergic / Immunologic (14)
- ☐ Severe allergic reaction
- ☐ Frequent infections

Do you have difficulties with any of the following activities? (Please CHECK all that apply)

- ☐ Bathing
- ☐ Toileting
- ☐ Eating
- ☐ Paying Bills
- ☐ Driving
- ☐ Dressing
- ☐ Taking medications
- ☐ Cooking
- ☐ Cleaning
- ☐ Shopping
- ☐ Using the phone
- ☐ Traveling

Have you used the following services in the past three months? (Please CHECK all that apply)

- ☐ Visiting Nurse
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Home health services
- ☐ Meal Program
- ☐ Speech Therapy
- ☐ Day Program
- ☐ Mental Health Services
- ☐ Other

PLEASE BRING COMPLETED FORM TO YOUR APPOINTMENT
Please bring Insurance cards (Authorization if Needed)
And available x-rays, MRI scans and previous medical records

THANK YOU FOR COMPLETING THIS FORM

Reviewed by Dr.:____ Date Reviewed:______________________ © UNAI, 2005