

NEUROINTERVENTIONAL ASSOCIATES P.A.
PERSONAL HISTORY FORM, page 1 of 2

Patient Name _____ Date _____

Referred by _____ Family doctor _____

Date of Birth _____ Height _____ Wt. _____ Right Left handed (circle one)

Medical problems I'm seeing a Neurointerventional Radiologist for: _____

Past Medical History (check those that apply) : _____ Heart Attack _____ High Blood Pressure
_____ High Cholesterol _____ Migraines/Sinus Headaches _____ Ulcer _____ GERD/Reflux
_____ Coronary Artery Disease _____ Diabetes _____ Thyroid Disease _____ Stroke _____ Seizures
_____ Anxiety _____ Depression _____ Right/Left Cataract Surgery _____ Cancer _____ Asthma
_____ COPD/emphysema _____ Arthritis _____ Anemia _____ Head Trauma

Other medical problems: _____

Surgeries or hospitalizations: _____

Review of systems: (circle those that apply to YOU):

1. CONSTITUTIONAL: fevers loss of appetite night sweats weight loss weight gain
2. EYES: blurry vision vision loss double vision redness eye pain
3. EAR, NOSE, THROAT: snoring hearing loss ringing in ears earache sinus trouble
4. CARDIOVASCULAR: palpitations chest pain fainting legs swelling unable to lie flat
5. RESPIRATORY: cough shortness of breath hay fever
6. GASTROINTESTINAL: ingestion nausea vomiting
7. GENITAL/URINARY: frequent urination incontinence bedwetting
nighttime urination urgency
8. NEUROLOGIC: sleepiness tremors headaches dizziness numbness
9. PSYCHIATRIC: restless sleep depression anxiety forgetfulness
loss of consciousness
10. ALLERGY: hay fever sinus headaches hives
11. ENDOCRINE: irregular menses fatigue hot/cold intolerance
12. MUSCULOSKELETAL: neck pain back pain leg pain joint pain osteoporosis
13. HEMATOLOGIC: easy bleeding blood clots blood transfusion
14. SLEEP: restless legs nocturnal choking leg cramps insomnia
15. ACTIVITIES OF DAILY LIVING: Are you experiencing any of the following?
 1. Difficulty with bathing, dressing or feeding yourself? No Yes
 2. Difficulty getting out of chairs or bed? No Yes
 3. Decreased movement or strength in your arms or legs? No Yes
 4. Have you fallen in the last month, or have balance problems? No Yes
 5. Do you use a wheelchair, walker or cane? No Yes
 6. Do you often choke on food, liquids or pills? No Yes
 7. Difficulty communicating your needs to others? No Yes
 8. Decrease in the loudness of your voice or ability to speak clearly? No Yes

PERSONAL HISTORY FORM, page 2 of 2

Testing: Have you had any of these tests? (circle those that apply):

- MRI/MRA Yes No If so, of what/where/when? _____
- CT/CTA Yes No If so, of what/where/when? _____
- Ultrasound Yes No If so, of what/where/when? _____
- Angiogram Yes No If so, of what/where/when? _____

Medications: (list both prescriptions & over the counter) List attached

Medication name/ strength	Times per day	Who prescribed

Medication allergies: _____ None: _____

Social History: (circle those that apply)

- Occupation _____ Retired Unemployed Disabled Student Homemaker
- Marital Status: Single Married Widowed Divorced Separated
- I Live: Alone With Spouse With Children With Parents Own home
Group home Senior Apartment Assisted Living Nursing home
- Smoker: No Yes _____ packs per day date quit _____
- Alcohol: No Yes _____ drinks per week date quit _____
- Caffeinated Beverages: No Yes _____ cups per day
- Recreational Drugs: No Yes _____ what kinds and how often? _____
- Exercise: No Yes _____ Type and how often? _____
- Living Will: No Yes Full Resuscitation Do Not Resuscitate
No Vent GenMedCare
- Are you at risk for AIDS? No Yes

Family History: do any of your immediate family members suffer from: (check those that apply)

- _____ High Blood Pressure _____ Heart Disease _____ High Cholesterol _____ Cancer _____ Diabetes
- _____ Thyroid Disease _____ Dementia _____ Seizures _____ Parkinson's Disease
- _____ Muscle Weakness _____ Alcoholism _____ Stroke _____ Multiple Sclerosis _____ Aneurysm
- _____ Alzheimer's _____ Migraine _____ Sleep Apnea _____ Restless Legs
- _____ Learning Disorders

Mother: Living Age _____ Deceased Age _____
 Father: Living Age _____ Deceased Age _____
 Authorization to speak to a family member: No Yes Who? _____

Reviewed by: _____ Doctor's signature _____