Patient Name: _____ ☐ Male ☐ Female Date of Birth: _____

What are you here to see the doctor about today? _____

Have you had any testing ? ☐ Xrays ☐ CT Scan ☐ MRI ☐ EMG ☐ EEG ☐ Lab tests

If yes to any of the above, where and when did you have these tests ? When? _____

☐ Bellevue ☐ Firelands ☐ FTMC ☐ Fremont ☐ Magruder ☐ Willard ☐ Other _____

PERSONAL HEALTH INFORMATION

Do you smoke/use tobacco ? ☐ Yes ☐ No *or* Have you quit? _____ How long? _____ # packs/day _____

Do you drink alcohol or use drugs ? ☐ Never ☐ Rarely ☐ Occasionally ☐ Weekly ☐ Daily

Do you drink coffee, cola, or tea with caffeine or energy drinks? ☐ Yes ☐ No If yes, How much per day? _____

Do you have any allergies: ☐ Yes ☐ No If yes, please list: _____

Please check all that apply. Do you have or have you had any of the following?

☐ Cancer	☐ Diabetes	☐ Heart problems	☐ Depression
☐ High blood pressure	☐ Stroke / Blood clot	☐ Balance problems	☐ Memory loss
☐ Convulsions / Seizures	☐ Numbness/Tingling	☐ Vision problems	☐ Anxiety
☐ Fainting / dizziness	☐ Weakness / Fatigue	☐ Hearing problems	☐ Headaches
☐ Thyroid disorder	☐ Back injury or pain	☐ Arthritis / Joint pain	☐ Paralysis
☐ Trouble sleeping / excessive snoring		☐ Problems holding urine or bowel movement	

Please list any other **major illness** that you have: _____

Please list any **surgeries, serious injuries, or hospitalizations** you have had: _____

_____

Please list any **medications, herbs, nutritional supplements** that you take on a regular basis: _____

_____

Women: # of pregnancies ____ # of live births ____ Are you currently taking oral contraceptives or hormonal medications? ☐ Yes ☐ No

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FAMILY HEALTH INFORMATION

Do any of your **blood relatives** (mother, father, sister, brother, grandparents) have a history of any of the diseases listed below?

☐ Stroke	☐ Heart disease	☐ Seizures	☐ Arthritis	☐ Thyroid disease
☐ Migraines	☐ Parkinson's	☐ Multiple Sclerosis	☐ Depression	☐ Diabetes

☐ Other disease:_____

Date: _____ Signature: _____

Thank you for your cooperation in completing this form. This information will help us in evaluating your overall health and treatment.