AFFILIATED NEUROLOGY CENTER

25982 Pala, Suite 150
Mission Viejo, CA 92691

Telephone: 949-586-5500
Fax: 949-586-1600

PATIENT INFORMATION

Patient Last Name: _____First_____ Mi_____

Address: _____City: _____State:_____ Zip: _____

Home Phone ( ) _____Work Phone ( ) _____

Cell/Pager ( ) _____SSN: _____ Drivers License: _____

Date of Birth: _____/_____/_____Gender: □ M □ F Age: _____ Height: _____ Weight: _____

Contact number in case of emergency: _____ Relation_____

SOCIAL HISTORY

□ Single □ Married □ Separated □ Divorced □ Widowed Children? □ No □ Yes How Many?____

Employed: □ Yes (Occupation_____) □ No □ Student □ Retired

Tobacco Use: □ Yes ___ packs/day for __ years □ No □ never □ quit: how long ago? _____

Alcoholic beverages: □ Never □ Daily □ Moderately □ Rarely How much? _____

History of substance abuse? □ No □ Yes Please explain: _____

FAMILY HISTORY:

	Alive	Deceased	Hypertension	Stroke	Diabetes	Seizures	Cancer	Brain Tumor	Heart Attack	Arthritis
Father:	□	□	□	□	□	□	□	□	□	□
Mother:	□	□	□	□	□	□	□	□	□	□
Sister(s):	□	□	□	□	□	□	□	□	□	□
Brother(s):	□	□	□	□	□	□	□	□	□	□
Others:	□	□	□	□	□	□	□	□	□	□

ALLERGIES:

Any known allergies to **medications**? □ No □ Yes **If Yes, please list:**_____

Any known **food** allergies? □ No □ Yes **If Yes, please list:**_____

Do you have a history of reactions to **injections**? □ No □ Yes **If Yes, please list:**_____

HISTORY:

Please describe your symptoms: _____

_____

_____When did the symptoms start? _____

Have you had any treatment or tests for your symptoms? _____

MEDICATIONS: Please list all medications you are currently taking (include supplements and over the counter medications)

1._____2._____3._____4._____

5._____6._____7._____8._____

Do you have or have you had any of the following complaints?

Head, neck, eyes, ears, nose, throat	**Cardiovascular**
□ Eye pain or injury □ Impaired Hearing □ Glasses □ Dizziness □ Glaucoma □ Loss of consciousness □ Headaches □ Neck Stiffness	□ Chest Pain □ Shortness of breath on exertion □ Palpitations □ Swelling of hands/feet/ankles □ Heart attack □ Irregular heart beats
Skin	**Respiratory**
□ skin disease □ skin cancer □ skin rash	□ Chronic or frequent cough □ Frequent Bronchitis □ Shortness of breath □ Recent pneumonia
Gastrointestinal	**Urological**
□ Heartburn □ Nausea □ Bleeding from rectum □ Vomiting □ Abdominal pain	□ Frequent Urination □ Kidney stones □ Burning or painful urination □ Sexual dysfunctions
Hematological	**Musculoskeletal**
□ Blood Disease □ Phlebitis (inflammation of veins) □ Anemia □ Abnormal bruising or bleeding	□ Weakness of muscle/joint □ Difficulty walking □ Swelling/deformities of the joints □ Muscle's cramp
Gynecological N/A □	**Psychiatric**
□ Date of last PAP_____ Normal? □ Yes □ No □ Date of last mammogram_____ Normal? □ Yes □ No	□ Depression □ Anxiety □ Panic Attacks □ Hallucinations □ Insomnia □ Suicidal Ideations

_____ _____

Signature Date