NEUROSCIENCE
CONSULTANTS, PLC
1830 Town Center Dr, Suite 410 | Reston, VA 20190
Office: 703.478.0440 | Fax: 703.742.9210 | www.nscplc.com
Jon D. Peters, MD

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____ Date of Birth: _____

Primary Care Physician: _____

Referring Physician and Specialty: _____

Referring Physician's Address: _____

What is the reason for your visit today? _____

Which body part is affected? _____

How long have the symptoms been occurring? _____

Are the symptoms related to an injury? YES NO Was the injury work related? YES NO

If yes, what is the date of injury? _____ Job duties involved: _____

Are you currently working? YES NO Occupation: _____

Please check all that apply either currently or past:

- □ Stroke
- □ Dementia
- □ Facial Weakness
- □ Seizures or Epilepsy
- □ Headache
- □ Dizziness
- □ Neuropathy
- □ Diabetes
- □ Hypertension (high blood pressure)
- □ High cholesterol
- □ Heart attack
- □ Irregular heart beat or Arrhythmia
- □ Head Injury
- □ Asthma or COPD or Emphysema
- □ Cancer
- □ Numbness in Extremities
- □ Hepatitis
- □ Thyroid disease- Hyper or Hypo (circle one)
- □ Arthritis – Osteoarthritis / Rheumatoid arthritis (circle one)
- □ Depression
- □ Anxiety

Other: _____

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Past Surgical/Hospitalization History:

Date of Surgery/Hospitalization	Reason for Surgery/Hospitalization	Surgical Procedure

Family History:

Relative	Current Age	Medical Problem(s)
Mother		
Father		
Sibling(s); Specify:		
Grandmother/Grandfather		

Social History:

Marital Status: □ SINGLE □ MARRIED □ DIVORCED □ WIDOW/ER

Education: □ <12 YRS □ HIGH SCHOOL □ COLLEGE

Do you exercise? YES NO If so, how often per week? _____

Do you consume alcohol? YES NO If so, how many drinks per day/week? _____

Do you smoke? YES NO If so, how much per day? _____

Any illicit drug use? YES NO If so, how often? _____

In the past two weeks, have you:

Felt down, depressed, irritable, or hopeless? YES NO

Had little interest or pleasure in doing things? YES NO

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Allergies:

List any known allergies. If allergic to any drugs, specify the drug name: _____

_____

List of Current Medications:

Name of Medication	Dosage	Frequency

Attach a list if necessary

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If You are Here for the Treatment of Headaches/Migraines, Please List What You Have Tried in the Past (If Any) for Rescue and/or Prevention:

Name of Medication	When Was it Taken? (Year)	Why Was it Discontinued?

Attach a list if necessary

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE RECEIVED THIS INFORMATION, READ AND UNDERSTAND ITS CONTENTS. MY SIGNATURE ON THIS DOCUMENT IS VALID FOR 1 CALENDAR YEAR AND COVERS ALL SERVICES RENDERED WITHIN THAT YEAR. ANY MODIFICATIONS/ALTERATIONS TO THIS DOCUMENT ARE NULL AND VOID.

PATIENT NAME: _____

SIGNATURE OF PATIENT/REPRESENTATIVE: _____ DATE: _____