

NEUROSCIENCE CONSULTANTS, PLC

12007 Sunrise Valley Drive, Suite 120 | Reston, VA 201091-3460

1420 Beverly Road, Suite 347 | McLean, VA 22101-3730

Office: 703.478.0440 | Fax, Reston Location: 703.742.9210 | Fax, McLean Location: 571.282.4715 | www.nscplc.com

Jon D. Peters, MD Ruben Cintron, MD Morgane Morris, FNP

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:

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

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

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:** _____