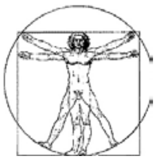


Colorado Neurodiagnostics, PLLC
Health History Questionnaire

Today's date: ______________ Primary Care Physician: ______________________________

Name: ____ Date of Birth: __________________

Reason for visit: ____

Referring Physician: ____

Current Medications (please include strength and schedule): Are you allergic to iodine? ☐ Yes ☐ No

1. ______________________________ 6. ______________________________
2. ______________________________ 7. ______________________________
3. ______________________________ 8. ______________________________
4. ______________________________ 9. ______________________________
5. ______________________________ 10. ______________________________

Allergies (please list the type of reaction you had): ______________________________

____

Please check any of the following conditions you have had:

☐ High blood pressure	☐ Diabetes	☐ High cholesterol	☐ Heart disease
☐ Epilepsy/Seizures	☐ Carotid disease	☐ Multiple Sclerosis	☐ Stroke or TIA
☐ Head injury	☐ Blindness	☐ Depression/Anxiety	☐ Fainting spells
☐ Parkinson's disease	☐ Glaucoma	☐ Neck/Back pain	☐ Arthritis
☐ Bleeding/Clotting disorder	☐ Lupus	☐ Sarcoidosis	☐ Lung disease
☐ Ulcer disease	☐ Cancer	☐ Kidney disease	☐ Prostate disease
☐ AIDS/HIV	☐ Thyroid disease	☐ Meningitis/Encephalitis	☐ Asthma

☐ Other: ____

Please list any surgeries (including eye surgery) you have had and approximate date/s:

1. ______________________________ 4. ______________________________
2. ______________________________ 5. ______________________________
3. ______________________________ 6. ______________________________

Social History

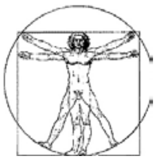
Are you married? ☐ Yes ☐ No Do you have children? ☐ Yes ☐ No

I live with: ____

Do you smoke? ☐ Yes - # of packs p/day _______ ☐ Quit - # of years ago _______ ☐ Never have

Do you drink? ☐ Yes - # of drinks p/day _______ ☐ Rarely/Socially ☐ No

Do you use illegal substances? ☐ Yes ☐ Quit - # of years ago _______ ☐ Never have



Colorado Neurodiagnostics, PLLC
Health History Questionnaire

Family Medical History

Relationship to You	Diagnosis	Age of Occurrence	If applicable, Cause of death

---

Please indicate if you have any of the following symptoms:

Constitutional	☐ Weight loss/gain ☐ Fatigue ☐ Fever/sweats ☐ Decreased appetite
Ear/Nose/Throat	☐ Hearing loss ☐ Ringing in ears ☐ Hoarseness/Loss of voice ☐ Difficulty swallowing ☐ Nose bleeds
Eyes	☐ Blurred vision ☐ Double vision ☐ Painful vision ☐ Droopy eyelids ☐ Vision loss
Cardiovascular	☐ Chest pain ☐ Palpitations ☐ Leg pain with exertion ☐ Syncope/Fainting
Respiratory	☐ Shortness of breath ☐ Cough ☐ Snoring
Allergic/Immunologic	☐ Frequent infections ☐ Drug allergies ☐ Environmental allergies
Gastrointestinal	☐ Nausea/vomiting ☐ Diarrhea ☐ Constipation ☐ Abdominal pain ☐ Stool incontinence
Genitourinary	☐ Bladder incontinence ☐ Urinary frequency ☐ Urinary hesitancy ☐ (female) Miscarriage ☐ (male) Impotence
Endocrine	☐ Cold/heat intolerance ☐ Excessive thirst ☐ Diabetes ☐ Thyroid disorder
Hem/Lymph	☐ Easy bruising ☐ Abnormal bleeding ☐ Feet swelling ☐ Anemia ☐ Cancer
Musculoskeletal	☐ Back pain ☐ Joint pain ☐ Joint swelling ☐ Muscle ache/cramps
Skin	☐ Rash ☐ Excessive dryness ☐ Lesions
Psychiatric	☐ Depressed mood ☐ Anxiety ☐ Suicidal thoughts ☐ Hallucinations ☐ Memory loss ☐ Confusion
Neurologic	☐ Extremity or facial weakness ☐ Numbness/tingling ☐ Loss of consciousness ☐ Headache ☐ Difficulty walking ☐ Imbalance ☐ Staring spells ☐ Scalp tenderness ☐ Dizziness/vertigo ☐ Drooling ☐ Tremor ☐ Difficulty speaking/writing/reading ☐ Change in handwriting ☐ Loss of taste or sense of smell

All information provided on this form is accurate as given by the patient/guardian.

Patient signature: ____

OR

Signature of Guardian/POA: ____________________________________ Relationship: _____________