

ATLANTA NEUROLOGICAL ASSOCIATES, P.C.

PATIENT MEDICAL INFORMATION

Date: _____

Name _____ Age _____ Occupation _____

Right Handed? _____ Left Handed? _____ Married? _____ Single? _____

PAST MEDICAL PROBLEMS:(Check those that apply)

- Artery/Vein Problems _____
- Neck/Back Problems _____
- High Blood Pressure _____
- Diabetes _____
- Heart Disease _____
- Thyroid Disease _____
- Arthritis _____
- Gastrointestinal Problems _____
- Lung Disease _____
- Kidney Disease _____
- Psychiatric Disorders _____
- Cancer _____
- High Cholesterol _____
- Anemia _____
- Other _____

REASON FOR VISIT: _____

PAST MEDICAL HISTORY/INJURIES? _____

LIST MEDICATIONS & Dosage: (Routine and as needed)

PAST SURGICAL HISTORY: _____

DRUG ALLERGIES: _____

FAMILY HISTORY: (Note any diseases)

Mother: _____

Father: _____

Siblings:(Brothers/Sisters) _____

Children: _____

HABITS: Smoking Yes / No How Many / Day _____ How Long _____

Alcohol Yes / No How Much? _____