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: ________________

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PAST MEDICAL HISTORY/INJURIES?__

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LIST MEDICATIONS & Dosage: (Routine and as needed)

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PAST SURGICAL HISTORY: __________

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DRUG ALLERGIES:______________________

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____
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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? ______________________