**Sylvia Zuniga-Barboni, M.D.**
**ADVANCED NEUROLOGY OF THE PALM BEACHES**
Board Certified in Neurology
American Board of Electrodiagnostic Medicine

# PATIENT MEDICAL HISTORY

**NAME** ________________________________ **AGE** ______ **DOB** ____________ **DATE** ______________

**HANDED:** □ **LEFT** □ **RIGHT** **GENDER:** □ **MALE** □ **FEMALE**

**REASON FOR VISIT:** ______________________________________________________________________

**MEDICATIONS AND DOSE:**

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**FAMILY HISTORY**
**RELATIVES ONLY, SPECIFY WHICH ONE**

| DISEASE | NO | YES WHICH RELATIVE |
|---|---|---|
| ALZHEIMER'S | | |
| MIGRAINE | | |
| CANCER | | |
| EPILEPSY | | |
| HEART DISEASE | | |
| HIGH BLOOD PRESSURE | | |
| DIABETES | | |
| STROKE | | |
| ANXIETY DEPRESSION | | |
| ADHD/ADD | | |
| OBESITY | | |
| OTHER | | |

**DRUG ALLERGIES:**
1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________

**DO YOU SMOKE?** □ **YES** □ **NO**
**HOW MUCH?** ___________________________________

**DO YOU DRINK ALCOHOL?** □ **YES** □ **NO**
**HOW MUCH?** ___________________________________

**PLEASE FILL OUT PAGE 2 → → → → →→ → →→ →**

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## HAVE YOU HAD A MEDICAL HISTORY OF ANY OF THE FOLLOWING?
## PLEASE SPECIFY YOUR CONDITION

| | | Specify Condition | Still Present |
|---|---|---|---|
| **Anemia or other Blood Disease** | □ yes □ no | ____________________________ | □yes □no |
| **Blood Pressure** | □ yes □ no | ____________________________ | □yes □no |
| **Cancer** | □ yes □ no | ____________________________ | □yes □no |
| **Heart Problems** | □ yes □ no | ____________________________ | □yes □no |
| **Endocrine,( thyroid, diabetes)** | □ yes □ no | ____________________________ | □yes □no |
| **Gastrointestinal** | □ yes □ no | ____________________________ | □yes □no |
| **Genitourinary** | □ yes □ no | ____________________________ | □yes □no |
| **Head, Eyes, Ears, Nose, Throat** | □ yes □ no | ____________________________ | □yes □no |
| **Psychiatric** | □ yes □ no | ____________________________ | □yes □no |
| **Respiratory** | □ yes □ no | ____________________________ | □yes □no |
| **Skin** | □ yes □ no | ____________________________ | □yes □no |
| **Unexplained Weight Loss** | □ yes □ no | ____________________________ | □yes □no |
| **Neurologic:** | | | |
| **1. Stroke** | □ yes □ no | ____________________________ | □yes □no |
| **2. Seizures** | □ yes □ no | ____________________________ | □yes □no |
| **3. Headache** | □ yes □ no | ____________________________ | □yes □no |
| **4. Numbness/Tingling** | □ yes □ no | ____________________________ | □yes □no |
| **5. Neck/Back Pain** | □ yes □ no | ____________________________ | □yes □no |
| **6. Other Neurologic Illness** | **(specify)** | ______________________________ | □yes □no |

| Surgeries or Hospitalizations | Date | Surgeries or Hospitalizations | Date |
|---|---|---|---|
| 1. _______________________ | _________ | 5. _______________________ | _________ |
| 2. _______________________ | _________ | 6. _______________________ | _________ |
| 3. _______________________ | _________ | 7. _______________________ | _________ |
| 4. _______________________ | _________ | 8. _______________________ | _________ |