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:

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. _____	_____