Swedish Neuroscience Specialists Medical History Form

Name: _____ **Date:** _____

DOB: _____ **Age:** _____ **Occupation:** _____

HT: _____ **WT:** _____ **Dominant Hand:** ❑ **Right** ❒ **Left** ❒ **Ambidextrous**

Reason for this visit: _____

Other Medical Problems:	**Past Surgeries:**

Have you ever had: ❒ **Fever related childhood seizures** ❒ **Meningitis** ❒ **Encephalitis** ❒ **Serious head injury**

Allergies:

Tobacco use:	❒ **Never**	❒ **Previously, but quit** **Date stopped:**	❒ **Current** _____**packs per day.**

Use of Alcohol:	❒ **Daily**	❒ **Moderately**	❒ **Rarely**	❒ **Never**

Recreational Drug Use:	❒ **Never**	❒ **Yes**	**Type/Frequency:**

Review of systems: Do you currently have any of the following problems?		***If yes, please explain:***
Neurological problems(i.e. Headaches, stroke, memory loss)	❒ **Yes** ❒ **No**	
Eye disease(i.e. glaucoma, cataracts, wandering or lazy eye)	❒ **Yes** ❒ **No**	
Chronic Fever, unexpected weight loss, fatigue	❒ **Yes** ❒ **No**	
Ear/Nose/Throat problems(i.e. hearing loss, sinus problems)	❒ **Yes** ❒ **No**	
Heart problems(i.e. chest pain, irregular heart beat)	❒ **Yes** ❒ **No**	
Respiratory problems(i.e. shortness of breath, wheezing)	❒ **Yes** ❒ **No**	
Gastrointestinal problems(i.e. heartburn, abdominal pain, diarrhea)	❒ **Yes** ❒ **No**	
Urinary problems(i.e. pain, incontinence, blood in urine)	❒ **Yes** ❒ **No**	
Endocrine problems(i.e. diabetes, thyroid disease, menstrual problems)	❒ **Yes** ❒ **No**	
Psychiatric problems(i.e. depression, anxiety, anger problems)	❒ **Yes** ❒ **No**	
Reproductive problems(i.e. pregnancy, prostate problems, impotence, etc.)	❒ **Yes** ❒ **No**	

Family medical history: Any immediate family members with a history of either Epilepsy or neurological disease?

❒ **Yes** ❒ **No**	**Explain:**	
		MD initials:

Medical History Form continued:

Referring Provider: Name:	Address:	Phone:
Primary Care Provider: Name:	Address:	Phone:
Legal Next of Kin: Name:	Address:	Phone:

Living Situation: ❑ Live Alone ❒ With Family ❒ With Friends ❒ Homeless ❒ Other

Date of injury and/or when this problem began:

Is this injury/problem work related? ❒ Yes ❒ No (if yes, please list claim number and name/number of case manager:

MRI Information:

A. Do you have any metal implants such as:		
Aneurysm clip(s):	❒ Yes ❒ No	If yes, what year:
Cardiac pacemaker:	❒ Yes ❒ No	If yes, what year:
Neuro-stimulator:	❒ Yes ❒ No	If yes, what year:
Cochlear Implant:	❒ Yes ❒ No	If yes, what year:
SWAN/EPI catheter:	❒ Yes ❒ No	If yes, what year:
Bullets/Bullet fragments:	❒ Yes ❒ No	If yes, what year:

B. Do you have significant claustrophobia: ❒ Yes ❒ No | Will you need sedation: ❒ Yes ❒ No

C. Do you have a previous history of working with metal? (Such as welder, sheet metal worker, etc.) ❒ Yes ❒ No

D. Are you allergic to IV contrast dye, Iodine or shellfish? ❒ Yes ❒ No

E. If female, is there a chance that you could be pregnant? ❒ Yes ❒ No

Medication Record

Patient Name:
Date of Birth:

In order to prevent mistakes with your medications, please transfer the information from the labels on your prescription bottles to this sheet. Accurate information is required for your safety.

Name of Medication (e.g.: Plavix)	**Dosage/Strength: (e.g.: 250mg)**	**Schedule: (e.g.: 1 tablet 2x per day)**	**Reason for taking this medication:**