Patient History Form

Patient Name: [Patient Name]

Date of Birth: [Date of Birth]

Contact Information: [Phone Number, Email]

Date of Visit: [Date]

Chief Complaint

[Describe the primary neurological symptom(s) that brought the patient in for evaluation]

History of Present Illness

[Detail the onset, duration, and characteristics of symptoms, including any factors that worsen or relieve them]

Past Medical History

[List any past neurological conditions, surgeries, or other relevant medical history]

Medication History

[List current and past medications, including dosage and frequency]

Family History

[Detail any family history of neurological disorders or significant health issues]

Social History

[Include lifestyle factors like smoking, alcohol use, occupation, and exercise habits]

Neurological Symptoms Review

- [List any additional neurological symptoms experienced, such as headaches, seizures, numbness, etc.]

Review of Systems

[Summarize findings from a review of other body systems that may relate to neurological symptoms]

Summary and Next Steps

[Brief summary of findings and recommended follow-up or diagnostic tests]

Physician Signature: ______________________

Date: [Date]