GREATER PITTSBURGH NEUROLOGY CONSULTANTS
MEDICAL HISTORY SHEET

Please complete the following information so that we may provide you with the best possible care.
Thank You.

Patient Name _____ Date _____

Age _____ Height _____ Weight _____ Allergies _____

REASON FOR VISIT

Medical _____ Accident _____ Auto _____ Work-Related _____ Other _____

Chief Complaint or Problem _____

_____

_____

Referring MD _____ Phone _____

Address _____

MEDICAL HISTORY

Do you smoke? No _____ Yes _____ How often? _____

Do you drink? No _____ Yes _____ How often? _____

Personal or Family History *(Please check all that apply. If you have a family history, please list the relationship such as mother, father, etc.)*

Arthritis	Self _____	Family _____	Relationship _____
Cancer	Self _____	Family _____	Relationship _____
Diabetes	Self _____	Family _____	Relationship _____
Digestive	Self _____	Family _____	Relationship _____
Frequent Bleeding	Self _____	Family _____	Relationship _____
Headaches	Self _____	Family _____	Relationship _____
Heart Disease	Self _____	Family _____	Relationship _____
Hepatitis	Self _____	Family _____	Relationship _____
Hypertension	Self _____	Family _____	Relationship _____
Liver Disease	Self _____	Family _____	Relationship _____
Seizures	Self _____	Family _____	Relationship _____
Strokes	Self _____	Family _____	Relationship _____
Other Neurological	Self _____	Family _____	Relationship _____
Substance Abuse	Self _____	Family _____	Relationship _____
Thyroid Disease	Self _____	Family _____	Relationship _____
Other	Self _____	Family _____	Relationship _____