WK Neurology Clinic
2400 Hospital Drive Ste 310
Bossier City, LA 71111
Phone (318) 212-7430

Date: _____

PATIENT HISTORY FORM

NAME:_____ DATE OF BIRTH:_____

AGE:_____ SEX: ___ Male ___Female **HEIGHT:_____ WEIGHT:_____**

OCCUPATION:_____ MARITAL STATUS: __Married ___Divorced ___Widowed ___Single

REASON FOR VISIT:_____

REFERRING PHYSICIAN:_____ PRIMARY PHYSICIAN:_____

MEDICAL HISTORY: Have you had any of the following? Check all that apply:

____ Stroke	____Heart Disease	____Thyroid Problems	____Lung Problems
____Seizures	____Arrhythmia	____Diabetes	____Arthritis
____TIA	____Heart Attack	____High Cholesterol	____Other:_____
____Brain Tumor	____Poor Circulation	____Ulcer/Stomach Problems	
____Migraine Headaches		____Kidney Stones	

SURGERY HISTORY: _____ _____ _____
_____ _____ _____

SOCIAL HISTORY:
Do you smoke?_____ How many packs a day?_____ How long?_____ Quit?_____ When?_____
Do you drink alcohol(beer, wine, mixed drinks)?_____ How often?_____

FAMILY HISTORY: Check all that apply:

_____Stroke	_____Brain Tumor	_____Parkinson's Disease
_____TIA	_____Seizures	_____Alzheimer's Disease

Have you ever had any of the following?

_____CT scan	If yes, when?_____	Where?_____
_____MRI scan	If yes, when?_____	Where?_____
_____MRA scan	If yes, when?_____	Where?_____
_____EMG	If yes, when?_____	Where?_____
_____EEG	If yes, when?_____	Where?_____
_____Lumbar Puncture?	If yes, when?_____	Where?_____

Have you seen a neurologist in the past?
_____ Yes If yes, who?_____
_____ No For what reason?_____

Have YOU had any RECENT problems with the following?

NO	YES		NO	YES		NO	YES		NO	YES	
___	___	Vision Change	___	___	Chills	___	___	Abdominal pain	___	___	Rash
___	___	Hearing Loss	___	___	Fever	___	___	Nausea	___	___	Neck pain
___	___	Vertigo	___	___	Weight gain	___	___	Vomiting	___	___	Back pain
___	___	Ringing in the ear	___	___	Weight loss	___	___	Black tarry stools	___	___	Joint pain
___	___	Change in speech	___	___	Nasal Congestion	___	___	Trouble swallowing	___	___	Radiating pain to arms/ legs
___	___	Muscle weakness	___	___	Sore Throat	___	___	Pain with urination			
___	___	Numbness/tingling	___	___	Pain with breathing	___	___	Blood in urine			
___	___	Pain to touch	___	___	Cough	___	___	Depression	___	___	Easy bleeding
___	___	Loss of temperature sensation	___	___	Shortness of breath	___	___	Significant stress	___	___	Easy brusing
			___	___	Blood when coughing	___	___	Increased stress	___	___	Hay fever
___	___	Change in bowel habits	___	___	Chest pain				___	___	Hives
___	___	Change in bladder habits	___	___	Irregular heartbeat palpitations						
___	___	Loss of bowel function									
___	___	Urinary incontinence									
___	___	Trouble walking									
___	___	Headache									

CURRENT MEDICATIONS (include dosage and how often)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES TO MEDICATIONS: _____