Medical History Form

Northeast Georgia PHYSICIANS GROUP

Today's Date: _____

Name: _____ **Date of Birth**: _____ **Age**: _____

Marital Status: _____ **Occupation**: _____ **Education**: _____

Physician who referred you: _____ **Handedness:** ☐ Right ☐ Left

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Please describe the main problems/concerns that bring you to see us:

_____

_____

_____

Have you had other tests for this problem? ☐ Yes ☐ No

If yes, specify:_____

When did the problem start? _____ It started: ☐ gradually ☐ suddenly ☐ off & on

Has the problem changed over time? ☐ Yes ☐ No If yes, *better* or *worse*? (circle one)

Have you had any recent major life changes or stressors? ☐ Yes ☐ No

If yes, specify: _____

Have you ever been treated for depression/anxiety, or other psychiatric conditions? ☐ Yes ☐ No

If yes, specify: _____

List past surgeries:

_____

_____

List names of current medications:

Name of medication	Dosage	Times per day	Prescribing Doctor
Example: Lasix	*20mg*	*Twice a day*	*Dr. Jones*

Living situation: ☐ Home ☐ Staying with relative _____ ☐ Assisted living ☐ Other _____

Do you depend on anyone else to help out with household activities? ☐ Yes _____ ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Is this problem related to any litigation, insurance claim, or application for disability? ☐ Yes ☐ No

Medical History (check all that apply):

- ☐ Multiple Sclerosis (MS)
- ☐ Parkinson's
- ☐ High Blood Pressure
- ☐ Alzheimer's
- ☐ Aneurysm
- ☐ Seizures / Epilepsy
- ☐ Diabetes
- ☐ Anemia
- ☐ Meningitis / Encephalitis
- ☐ Heart Problems/Heart Attack
- ☐ Coma
- ☐ TIA or "Mini-Stroke"
- ☐ Cancer (*type*_____)
- ☐ Radiation therapy
- ☐ Chemotherapy
- ☐ Thyroid problems
- ☐ Hearing Problems
- ☐ Kidney Problems
- ☐ Circulation /Vascular problems
- ☐ Polio
- ☐ Pacemaker / Defibrillator
- ☐ Substance Use
- ☐ Infectious Disease (*e.g. HIV/TB*)
- ☐ Chronic Pain
- ☐ Developmental / Growth Problems
- ☐ Vision Problems
- ☐ Taste / Smell Changes
- ☐ Learning disability
- ☐ Sleep apnea/Sleep problems
- ☐ Headaches
- ☐ Lung / Breathing Problems
- ☐ Poor appetite
- ☐ Head Injury
- ☐ Stroke
- ☐ Hallucinations

Current Symptoms (check yes/no):

Trouble remembering things	☐ YES	☐ NO
Difficulty in finding the right word or using wrong words	☐ YES	☐ NO
Being less able to manage money and finances (e.g., paying bills, budgeting)	☐ YES	☐ NO
Being less able to manage medications independently	☐ YES	☐ NO
Feeling depressed or other mood changes	☐ YES	☐ NO
Having sudden, short episodes of unconsciousness, memory loss, confusion	☐ YES	☐ NO
Having sudden, short episodes of jerking, falling, or other abnormal movements	☐ YES	☐ NO
Being less able to keep up with activities around the house	☐ YES	☐ NO
Problems walking or getting up from a chair	☐ YES	☐ NO
Problems with fine or small movements (like fastening buttons or writing)	☐ YES	☐ NO
Seeing or hearing things that others do not see or hear	☐ YES	☐ NO
Problems with posture, balance, or falls	☐ YES	☐ NO
Repeating questions, stories or conversations over and over	☐ YES	☐ NO
Changes in behavior or personality	☐ YES	☐ NO
Weakness, numbness or a "dead feeling" on one side of the body	☐ YES	☐ NO
Loss of vision, double vision, or other vision changes	☐ YES	☐ NO
Dizziness or vertigo (sense of rotation)	☐ YES	☐ NO
Losing the ability to understand what people were saying	☐ YES	☐ NO
Changes in the ability to speak or write	☐ YES	☐ NO