NEUROLOGY CENTER OF FAIRFAX, LTD.

Fairfax Office 3020 Hamaker Ct, Suite 400, Fairfax, VA 22031
Reston Office 1830 Town Center Dr, Suite 305, Reston, VA 20190
Office Phone 703.876.0800 | **Fax** 703.876.0866
After hours emergency 703.755.1450

NAME_________________________________ DOB _______________ PATIENT #_______________

Past Medical History

YES		YES	
	Diabetes Mellitus		Migraine Headache
	Type 1(Childhood/Juvenile)		Other Headache – type: ___________________
	Type 2 (Adult onset)		ALS/Lou Gehrig's Disease
	Hypertension (High Blood Pressure)		Myositis – Muscle Inflammation/Pain
	Heart Disease – Any Heart Problem		Myasthenia Gravis
	Coronary Disease/Heart Attack/Angina		Neuritis – Nerve Pain
	Atrial Fibrillation or Irregular Heart Beat		Nerve Palsy/Paralysis – i.e., Facial Paralysis
	Heart failure (CHF)		Neuropathy/Numbness
	High Cholesterol		Radiculopathy (Pinched/Trapped Nerve)
	Joint Problems/Arthritis/Osteoarthritis		Cervical
	Benign Cancer		Thoracic
	Malignant Cancer (including Skin)		Lumbar
	Thyroid Disorders (Hyper- or Hypothyroid)		Stroke/TIA /Paralysis
	GI Disorders		Intracranial Hemorrhage
	Reflux (Gastroesophageal Disease – GERD)		Carotid Stenosis/Carotid Surgery
	Stomach Ulcer/Gastric Irritation		Cerebral Aneurysm/Surgery
	GI Bleed		Dementia/Memory Loss
	Eye Problem/Vision Loss/Double Vision		Restless Leg Syndrome
	Liver Disease		Parkinson's Disease
	History of Infections – incl. Lyme, HIV, Hepatitis		Tremor
	Pulmonary Disease – Any Lung Problem		Psychiatric Disorders including AD/HD
	Pneumonia		Depression
	Asthma		Anxiety
	Chronic Obstructive Pulmonary Disease (COPD)		Genetic History (Yours)
	Kidney Disease – Any Kidney Problem		Autoimmune Disease – Lupus, Rheum. Arthritis
	Hematologic Disorders – Blood Problem		Multiple Sclerosis
	Easy Bleeding		Cervical Spine (Neck)Surgery
	Seizure Disorder/Epilepsy		Thoracic Spine Surgery
	Fainting (Syncope)		Lumbar Spine Surgery
	Sleep Disorders – Trouble Sleeping		Surgery – list any other surgeries
	Sleep Apnea		Brain Tumor
			None/Negative

Additional Information/ Other medical history/tests not listed:

____

____

____

NEUROLOGY CENTER OF FAIRFAX, LTD.

Fairfax Office 3020 Hamaker Ct, Suite 400, Fairfax, VA 22031
Reston Office 1830 Town Center Dr, Suite 305, Reston, VA 20190
Office Phone 703.876.0800 | Fax 703.876.0866
After hours emergency 703.755.1450

NAME________________________________ DOB _______________ PATIENT #_______________

Family and Social History

	Mother	Father	Sister	Brother		Mother	Father	Sister	Brother
Diabetes Mellitus					Sleep Condition/Insomnia				
Diabetes Mellitus Type 1					Sleep Apnea				
Diabetes Mellitus Type 2					Migraine/Other Headache				
Hypertension/High Blood Pressure					Peripheral Nerve/Muscle				
Heart Disease – Any heart problem					Polyneuropathy - Neuropathy				
Coronary Disease/Heart Attack/Angina					Stroke Syndrome/TIA				
Atrial Fibrillation – Irregular Heartbeat					Intracranial Hemorrhage				
Heart failure (CHF)					Dementia				
High Cholesterol					Restless Leg Syndrome				
Joint Problems Arthritis					Parkinson's Disease				
Osteoarthritis					Tremor				
Benign Cancer					Psychiatric Disorders				
Malignant Cancer (including Skin)					Depression				
Thyroid Disorders – Hyper/Hypo					Anxiety				
GI Disorders or Liver Problem					Genetic History				
History of Infections (Hepatitis/HIV)					Autoimmune Disease				
Pulmonary Disease					Multiple Sclerosis				
Pneumonia					Other illness not listed				
Asthma									
Obstructive Pulmonary Disease (COPD)									
Kidney Disease – any type									
Easy Bleeding									
Seizure Disorder/Epilepsy									
Fainting (Syncope)									

- [ ] **Family history is negative**
- [ ] Family history is unobtainable
  - [ ] Patient adopted
  - [ ] Patient orphaned

Y	Right-handed
Y	Left-handed

Tobacco Assessment:

Y	N	Do you use tobacco products?

Smoking Status

Y	N	Current every day smoker
Y	N	Current some day smoker
Y	N	Former smoker
Y	N	Never smoked
Y	N	Smoker, status unknown
Y	N	Unknown if ever smoked

Y	N	Caffeine Use

Occupation:

Y	N	Working Full Time Occupation:______________________
Y	N	Working Part Time Occupation: ______________________
Y	N	Unemployed
Y	N	Homemaker
Y	N	Retired
Y	N	Currently on disability
Y	N	Student
Y	N	Military service

Exercise Habits

Y	Good exercise habits (≥ 3 days p/wk)
Y	Poor exercise habits

Marital History

Y	N	Currently married
Y	N	Domestic Partner
Y	N	Single
Y	N	Separated
Y	N	Divorced
Y	N	Widowed

Alcohol Assessment

Y	N	Do you drink alcohol?
Y	N	Social drinker
Y	N	Moderate drinker (2 drinks/day or fewer)