DAYTON CENTER FOR NEUROLOGICAL DISORDERS
DCND

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provide better understand your medical concerns and conditions.
If you cannot remember specific details, please approximate. Add any notes you think are important.
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

CURRENT MEDICATIONS - PLEASE LIST THE MEDICATION YOU CURRENTLY TAKE. IF NONE. PLEASE CIRCLE "NONE" NONE

Name of Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

MEDICATION/ALLERGY SENSITIVITY - PLEASE LIST ALL MEDICATION ALLERGIES. IF NONE, PLEASE CIRCLE "NONE". NONE NONE

1.
2.
3.
4.
5.
6.

YOUR PROVIDERS - PLEASE LIST ALL OF DOCTORS YOU CURRENTLY SEE

1.
2.

PHARMACIES - LIST NAME, ADDRESS AND PHONE NUMBERS, BOTH LOCAL AND MAIL AWAY.

1.
2.

PAST MFDICAL HISTORY – CHECK ALL BOXES THAT APPLY TO YOU. IF NONE. PLEASE CIRCLE "NONE. NONE

☐ Brain Tumor	☐ Polio	☐ Allergies/Hay Fever
☐ Dementia	☐ Peripheral Neuropathy	☐ Anemia
☐ Headaches – Migraine	☐ Muscle Disease	☐ Bleeding Disorder
☐ Headaches – Tension	☐ Other Neuromuscular Disease	☐ Cancer
☐ Headache - Cluster	☐ Arthritis	☐ Diabetes
☐ Head Trauma/Injury	☐ Obstructive Sleep Apnea	☐ Exposure to Toxins
☐ Intracranial Bleed	☐ Poor Sleep Quality	☐ Genito-Urinary Disease
☐ Stroke	☐ Daytime Sleepiness	☐ HIV
☐ TIA	☐ Sleep Disturbance	☐ Hyperthyroidism
☐ Carotid Artery Disease	☐ Narcolepsy	☐ Hypothyroidism
☐ Syncope/ Passing Out	☐ Coronary Artery Disease	☐ Kidney Disease
☐ Seizures/Epilepsy	☐ Heart Attack (MI)	☐ Liver Disease
☐ Parkinson's Disease	☐ Atrial Fibrillation	☐ Measles
☐ Multiple Sclerosis	☐ Other Arrhythmias	☐ Menstrual/ Sexual Dysfunction
☐ Anxiety/Panic Attacks	☐ Cardiac Valve Disease	☐ Mumps
☐ Depression	☐ Heart Murmur	☐ Peptic Ulcer Diseases
☐ Cervical Spine Diseases	☐ Congestive Heart Failure	☐ Peripheral Vascular Disease
☐ Neck Injury	☐ Hypertension	☐ Reflux
☐ Lumbar Spine Disease	☐ COPD	☐ Tuberculosis
☐ Back Injury	☐ Asthma	☐ Venereal Disease
☐ Spinal Cord Injury/Disease	☐ Pneumonia	☐ Other:

REVIEW OF SYSTEMS - PLEASE CHECK ALL THAT APPLY TO YOU. IF NONE, PLEASE CIRCLE "NONE" NONE

☐ Headache	☐ Stiffness	☐ Tinnitus	☐ Personality Changes	☐ Weight Loss
☐ Speech Difficulty	☐ Poor Balance	☐ Syncope	☐ Lethargy	☐ Fever
☐ Double Vision	☐ Trouble Walking	☐ Seizures	☐ Fatigue	☐ Cardiac
☐ Other Visual Changes	☐ Clumsiness	☐ Other spells	☐ Pain	☐ Respiratory
☐ Trouble Swallowing/Dysphagia	☐ Drooling	☐ Memory Loss	☐ Ear Nose Throat	☐ Peripheral Vascular
☐ Loss of Taste/Smell	☐ Bladder Problems	☐ Confusion	☐ Difficulty Chewing	☐ Arthritis
☐ Weakness: Arms/ Legs	☐ Bowel Problems	☐ Poor Concentration	☐ Hoarseness	☐ Dermatologic
☐ Numbness: Arms/ Legs	☐ Dizziness	☐ Depression	☐ Nausea	☐ Hematologic
☐ Facial Numbness	☐ Vertigo	☐ Hallucinations	☐ Vomiting	

FAMILY HISTORY - PLEASE CHECK ALL THAT APPLY. IF UNKNOWN, PLEASE CIRCLE "UNKNOWN" UNKNOWN

PROBLEM	IMMEDIATE RELATION	PROBLEM	IMMEDIATE RELATION
☐ Aneurysm		☐ Kidney Disease	
☐ Arthritis		☐ Migraines	
☐ Bleeding or Clotting Disorders		☐ Multiple Sclerosis	
☐ Brain Tumor		☐ Muscle Disease	
☐ Cancer (Malignant Neoplastic Disease)		☐ Neuropathy	
☐ Connective Tissue Disorder		☐ Parkinson's Disease	
☐ Dementia/Alzheimer's		☐ Psychiatric Disorders	
☐ Diabetes		☐ Restless Leg	
☐ Epilepsy/Seizures		☐ Snore	
☐ Headaches		☐ Sleep Apnea	
☐ Heart Disease		☐ Spine Disease	
☐ Hypertension		☐ Stroke (Cerebrovascular Accident)	
☐ Insomnia		☐ Thyroid Disorder	

SOCIAL HISTORY/LIFESTYLE - PLEASE CIRCLE OR DESCRIBE IN THE ROWS BELOW

Smoking Status: Current / Former/ Never	Exercise Level None / Occasional / Moderate / Heavy
Tobacco- years of use:	Aspartame (diet drinks): Yes / No
Occupation:	Are you currently employed? Yes / No
Smoking (how much per day/week?):	Do you currently use a gait aid or other assisted device? Yes / No
Chewing Tobacco: Current / Former / Never	Single or Multi-level home? Single / Multi level
Alcohol Intake: None / Occasional / Moderate / Heavy	Any PT/OT in the last 12 months? Yes / No
Caffeine Intake: None / Occasional / Moderate / Heavy	How many steps in the home?
Illicit Drugs:	Sleep aids?: Yes / No
Marital Status: Single / Married / Divorced / Widow	Sleep aids-what type?:
Number of Children:	Sleep aids- how long?:
Education Level:	General Stress Level: High / Medium / Low

SURGICAL PROCEDURE

Month/Year	Illness/Operation	Complications (Y/N)

To my understanding, this represents an accurate portrayal of my health history. I will inform DCND as changes or updates occur.

Patient Signature Date

Patient Representative Signature Relationship Date