10300 N. Illinois Street, Suite 1000 | Indianapolis, IN 46290
555 E. County Line Road, Suite 102 | Greenwood, IN 46143

phone 317.805.2240 fax 317.527.4708 web circlecityneuro.com

Patient History Form

General Information

Name: ______________________________ Date of Birth: ____________ Age: _______

Date of last eye exam: ________________ Date of last neurology exam: ________________

Past Medical History

Do you have any history of the following?

- ☐ None
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma/Other Breathing Problems
- ☐ Cancer: ____________
- ☐ Carotid Artery Disease
- ☐ COPD/ Emphysema
- ☐ Depression
- ☐ Diabetes: ___ # of years
  Insulin? Yes or No
- ☐ Fibromyalgia
- ☐ GERD/ Reflux
- ☐ Gout
- ☐ Head or Spinal Injury
- ☐ Heart Disease
- ☐ High Blood Pressure:
  ______ # of years
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Psychiatric Disorders
- ☐ Rheumatoid Arthritis
- ☐ Seizures, Convulsions, or Fainting
- ☐ Sickle Cell Anemia
- ☐ Stroke or Other Neurologic Disease
- ☐ Temporal Disease
- ☐ Tuberculosis
- ☐ Other: ____________
  ____

Past Surgical History

Please list all surgeries, *including prior eye surgeries*, and the date of each.

	Date	Surgery	Surgeon
1.	__________	______________________________	______________________
2.	__________	______________________________	______________________
3.	__________	______________________________	______________________
4.	__________	______________________________	______________________
5.	__________	______________________________	______________________

Medication List

Please list all medications, the condition that is being treated by the medication, the dosage, and frequency.

	Medication Name	Condition Being Treated	Dosage	Frequency
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				

Allergies

Please list all allergies and their corresponding reactions.

	Medication (including anesthesia)	Reaction
1.	______________________	______________________
2.	______________________	______________________
3.	______________________	______________________
4.	______________________	______________________

	Other (including latex)	Reaction
1.	______________________	______________________
2.	______________________	______________________
3.	______________________	______________________

Family History

Please list family member or members (mother, father, sister, brother, grandmother, etc.) as applicable.

Eye Diseases	Systemic Diseases
☐ Glaucoma: ______________	☐ Diabetes: ______________
☐ Cataracts: ______________	☐ Stroke: ______________
☐ Macular Degeneration: ________	☐ Cancer: ______________
☐ Retinal Detachment: ________	☐ High Blood Pressure: ________
☐ Blindness: ______________	☐ Other: ______________
☐ Other: ______________	

Social History

Smoking:	Alcohol:	Other Drug Use:
☐ Never	☐ Never	☐ Never
☐ Smoker: ________ # PPD	☐ Occasional/ Social	☐ Yes
☐ Former Smoker	☐ 1-2 Drinks/ Day	☐ If yes, what type and how long? ________
	☐ 3-4+ Drinks/ Day	

Immunizations

Influenza vaccine:

- ☐ Yes:
  date of most recent vaccination _______
- ☐ No

Pneumococcus vaccine:

- ☐ Yes:
  date of most recent vaccination _______
- ☐ No

Review of Systems

Please select all that apply.

Cardiovascular:

- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Shortness of breath

Constitutional:

- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weakness
- ☐ Weight loss

Genitourinary:

- ☐ Genital discharge
- ☐ Genital lesions
- ☐ Painful urination
- ☐ Urgency

HEENT: (head, ears, eyes, nose,
and throat)

- ☐ Dizziness
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Ringing in ears
- ☐ Sore throat

Hematologic:

- ☐ Bleeding
- ☐ Bruising
- ☐ Tender nodes

Metabolic:

- ☐ Cold intolerance
- ☐ Excess hunger
- ☐ Excessive thirst
- ☐ Frequent urination
- ☐ Heat intolerance

Musculoskeletal:

- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle aches
- ☐ Stiffness
- ☐ Swelling

Neurological:

- ☐ Balance problems
- ☐ Headache
- ☐ Numbness
- ☐ Tingling

Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Irritability
- ☐ Nervousness

Respiratory:

- ☐ Cough
- ☐ Trouble breathing
- ☐ Wheezing

Skin:

- ☐ Hair loss
- ☐ Rash
- ☐ Skin lesions

Allergy:

- ☐ Itching
- ☐ Hives
- ☐ Chronic runny nose
- ☐ Seasonal allergies

Blood Pressure Control:

- ☐ Good BP control
- ☐ Borderline BP control
- ☐ Poor BP control
- ☐ Unknown BP control

Diabetes Control:

- ☐ Good DM control
- ☐ Borderline DM control
- ☐ Poor DM control
- ☐ Unknown DM control

Pregnancy:

- ☐ Pregnancy-first trimester
- ☐ Pregnancy-second trimester
- ☐ Pregnancy-third trimester