Town & Country Neurology

Sevak Ohanian, M.D.

HEALTH QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Why are you visiting us today? _____

ARE YOU CURRENTLY EXPERIENCING: (please circle any that apply)

GENERAL	WEIGHT CHANGE CHANGE IN SLEEPING HABITS FEVER CHILLS
SKIN	RASHES BRUISING HAIR LOSS
EYES	LOSS OF VISION DOUBLE VISION BLURRING OF VISION BOTHERED BY LIGHT PAIN REDNESS OF EYES SPOTS IN VISION
EARS & NOSE	CHANGES IN HEARING RINGING IN THE EARS EAR PAIN DIZZINESS NOSE DRAINAGE NOSE BLEEDS ALLERGIES
MOUTH/ THROAT/ NECK/LIP	TOOTH PAIN SORE THROAT NECK STIFFNESS
MOUTH ULCERS	NECK PAIN NECK SWELLING
RESPIRATORY	COUGH SPUTUM PRODUCTION BLOODY SPUTUM SHORTNESS OF BREATH WHEEZING
CARDIOVASCULAR	PALPITATIONS CHEST PAIN SHORTNESS OF BREATH ANKLE/FOOT SWELLING FAINTING HIGH BLOOD PRESSURE HEART MURMUR
GASTROINTESTINAL	TROUBLE SWALLOWING HEART BURN NAUSEA ABDOMINAL PAIN DIARRHEA CHANGE IN BOWEL HABITS
URINARY TRACT	FREQUENT URINATION PAINFUL URINATION INCONTINANCE TEA-COLORED URINE
REPRODUCTIVE	IMPOTENCE INFERTILITY PROSTATE PROBLEMS ESTROGEN REPLACEMENT
MUSCULO/SKELETAL	BONE OR JOINT PAIN STIFFNESS SWELLING DEFORMITY LIMITATION OF MOTION MUSCULAR TENDERNESS
NEUROLOGIC	SEIZURES HEADACHES LOSS OF CONSCIOUSNESS PARALYSIS/WEAKNESS LOSS OF BALANCE INCOORDINATION NUMBNESS HEAD TRAUMA CHANGE IN SENSE OF SMELL
PSYCHIATRIC	MOOD CHANGES EMOTIONAL PROBLEMS DEPRESSION ANXIETY OBSESSIONS HALLUCINATIONS

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Sevak Ohanian, M.D.

Patient Name: _____ **Date of Birth** _____

PAST MEDICAL HISTORY: (please circle any that apply)

Heart Disease	**YES**	**NO**	Seizure	**YES**	**NO**
Hypertension	**YES**	**NO**	Migraine	**YES**	**NO**
Cholesterol Disease	**YES**	**NO**	Thyroid Disease	**YES**	**NO**
Diabetes	**YES**	**NO**	Lupus	**YES**	**NO**
Stroke	**YES**	**NO**	Other_____		

PREVIOUS SURGERIES

Year of Surgery	**Procedure**

DRUG ALLERGIES

_____

_____

CURRENT MEDICATION

Name of Medication	**Dosage**	**Frequency**

SOCIAL HISTORY

Tobacco Usage	**YES**	**NO**	Alcohol Usage	**YES**	**NO**

FAMILY HISTORY

Heart Disease	**YES**	**NO**	Memory Loss	**YES**	**NO**
Strokes	**YES**	**NO**	Cancer	**YES**	**NO**
Diabetes	**YES**	**NO**	Migraine	**YES**	**NO**
Seizure	**YES**	**NO**			

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