



Olympia Neurology PLLC

525 Lilly Road, NE
Olympia, WA 98506

Today's Date _____

Medical History Questionnaire

Date _____ Referred by _____ Primary Physician _____

NAME _____

HANDEDNESS: LEFT RIGHT BOTH AGE: _____

Reason for appointment _____



Major Illnesses / Hospitalizations _____

Current Medications: _____

Allergies: _____

- History of: Diabetes Hypertension Kidney Disease Heart Disease Gout
 Ulcers Kidney Stones Emphysema Asthma Stroke Cancer

Other: _____

Surgeries: (operations, dates, complications) _____

Injuries: _____



Father: _____

Mother: _____

Siblings: _____

Children: _____

Other: _____



Birth Date: _____ Birth Place: _____ Marital Status: _____

Occupation: _____ Last Date of Work: _____

Habits: Tobacco: Yes No Packs per day _____ Year Stopped Smoking _____

Alcohol: Yes No Drinks per week _____ Coffee: Yes No

Current / Past other drug use: Yes No Drugs Used: _____

(Marijuana, Cocaine, Heroine, etc.)

For each of the following 12 Categories, please CIRCLE any symptoms or conditions you have now or have had recently; then, please place a CHECK beside the symptoms or conditions you are currently experiencing:

1. EYES / VISION

Loss or change of vision
 Eye pain or redness
 Excess watering
 Double or blurred vision
 Other _____

2. EARS / HEARING

Loss of hearing
 Buzzing or noise in ear
 Ear infection or drainage
 Other _____

3. NOSE / THROAT

Hoarseness
 Excessive sneezing
 Blocked nasal passages
 Nose bleeds
 Frequent runny nose
 Difficulty swallowing
 Other _____

4. RESPIRATORY

Wheezing
 Large quantity of sputum
 Excessive cough
 Shortness of breath
 Night sweats
 Pain with breathing
 Allergy or cold symptoms
 Pneumonia
 Emphysema
 Asthma
 TB
 Other _____

5. NEUROLOGICAL

Severe or frequent headaches
 Unusual head or neck tension
 Dizziness
 Fainting Spells
 Seizures or convulsions
 Shaking or twitching spells
 Paralysis of limbs
 Numbness or tingling of body parts
 Other _____

6. CARDIOVASCULAR

Chest pain
 Abnormal or fast heartbeat
 High blood pressure
 Low blood pressure
 Calf "cramps" with walking
 Sensitivity of finger/toes to cold
 Varicose veins
 Frequent and marked swelling of ankles and feet
 Heart murmur
 Rheumatic fever
 Other _____

7. GASTROINTESTINAL

Digestive difficulties
 Frequent nausea or vomiting
 Bloody vomitus
 Loss of appetite
 Stomach or abdominal pain
 Frequent loose bowel movements
 Recurring diarrhea
 Blood in the stools
 Hemorrhoids
 Frequent or severe constipation
 Diabetes
 Gallbladder diseases
 Inguinal, diaphragmatic hernia
 Loss of bowel control
 Other _____

8. GENITOURINARY

Urinary incontinence or dribbling
 Bloody urine
 Increased frequency of urination
 Chronic urgency of urination
 Difficulty starting or passing urine
 Painful urination
 Narrowing of urinary stream
 Flank pain
 Other _____

9. GENITAL - FEMALE

Breast pain
 Uterine fibroids or tumors
 Tubal infections
 Painful menses or excess bleeding
 Difficulty in sexual functioning
 Other _____

10. GENITAL - MALE

Penile pain
 Abnormality of testicles
 Scrotal swelling
 Varicocele
 Difficulty in sexual functioning
 Other _____

11. MUSCULOSKELETAL

Arthritis
 Polio
 Joint infection, swelling, pain or loss of motion
 Neck or back pain
 Sciatica
 Spine abnormality
 Brittle or soft bones
 Bone cyst or infection
 Bursitis
 Torn muscles or tendons
 Tendinitis
 Other _____

12. EMOTION / PSYCHOLOGY

Emotional illness
 Depression
 Recurrent feelings of loneliness or hopelessness
 Excessive worry or anxiety
 Severe tension
 Feelings of worthlessness
 Recurrent fear
 Abuse : sexual, emotional, physical
 Nervous exhaustion
 Frequent nightmares
 Hysterical attacks
 Constant unhappiness
 Difficulty sleeping
 Other _____

Signature _____

Name of person completing this form if other than patient: _____

Relationship to patient: _____