Health History

Patient's Name: ___DOB:_____Date of Service: _____

***ONLY* List any changes since your LAST visit *OR* If no changes, check box ☐**
****SIGN AND DATE ON PAGE TWO****

Have you developed any new health conditions?

_____
_____
_____

Have you had any new surgeries?

Procedure:_____ Date:_____
Procedure:_____ Date:_____
Procedure:_____ Date:_____
Procedure:_____ Date:_____

Have you developed any new medication allergies?

Please describe the reaction you had to the medication and the name of the medication:

_____
_____

Have you DISCONTINUED any MEDICATIONS?

_____
_____

Have you STARTED any new MEDICATIONS OR CHANGED dosages on a current medication? List MEDICATIONS *with* DOSAGE & FREQUENCY. Include over-the-counter medicines, vitamins, & herbal supplements:

1._____2. _____

3._____4. _____

5._____6. _____

Has anything changed in social history? If so please check off or record the changes only.
Marital Status:
__Never Married___Married___Divorced ___Separated____Widowed _Significant Other

Tobacco Use:____Cigarettes ___Cigars_____Pipe_____Vape ___Chewing Tobacco

Never Smoked/Chewed____When did you quit smoking/chewing?_____How old were you when you started smoking/chewing?_____How much do/did you smoke/chew per day? _____

Previous or current illicit drug use? _____

Do you drink alcohol?_____, If yes, how many drinks do you consume per day?_____

Highest education level achieved: _____

What is/was your occupation?_____Date Retired? _____

Health History

Patient's Name: ___DOB:_____Date of Service: _____

Has there been any changes to your family history? If so, please record the changes.

Family History:

	Alive	Deceased	Age now or at Death	Illnesses and/or Cause of Death
Father				
Mother				
Brother (s)				
Sister (s)				
Children				

_____ ___/___/_____

Patient Signature **Date**

Texas NeurologyCenter

Epworth Sleepiness Scale

DATE:_____

PATIENTNAME_____DATE OF BIRTH:_____

How likely are you to doze off or fall asleep in the following situations? Use the following scale to rate the likeliness of falling asleep.

Would never doze	**0**
Slight chance of dozing	**1**
Moderate chance of dozing	**2**
High chance of dozing	**3**

	0	**1**	**2**	**3**
1. Sitting and reading	☐	☐	☐	☐
2. Watching television	☐	☐	☐	☐
3. Sitting inactive in a public place (movie theatre)	☐	☐	☐	☐
4. As a car passenger for an hour without a break	☐	☐	☐	☐
5. Lying down to rest in the afternoon	☐	☐	☐	☐
6. Sitting and talking to someone	☐	☐	☐	☐
7. Sitting quietly after lunch without alcohol	☐	☐	☐	☐
8. In a car while stopping for a few minutes in traffic	☐	☐	☐	☐

Total _____

SIGNATURE:_____

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PATIENT HEALTH QUESTIONNAIRE – 9
(PHQ-9)

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

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use " √ "to indicate your answer)

			More	Nearly
		Several	than half	every
	Not at all	Days	the days	day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself---or that you are a failure or have left yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowing that other people could have noticed? Or the opposite ~~-b~~eing so fidgety or restless that you have been moving around more than usual	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in some way.	0	1	2	3
FOR OFFICE TO SCORE	0			
TOTAL SCORE =				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very Difficult
- ☐ Extremely Difficult

Patient's Initials:_____

FALLS SCREENING QUESTIONNAIRE

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

Have you fallen since your last visit?	☐ YES ☐ NO
If yes, how many times did you fall?	_____
Did your fall/s result in an injury?	☐ YES ☐ NO

_____
Patient's Initials