## 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:___________________

PATIENT NAME_______________________________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:___________________________

**PATIENT HEALTH QUESTIONNAIRE – 9**
**(PHQ-9)**

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

**Over the <u>last 2 weeks,</u> how often have you been bothered by any of the following problems?**
*(Use " √ "to indicate youranswer)*

| | Not at all | Several Days | More than half the days | Nearly every 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 being 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 <u>any</u> problems, how <u>difficult</u> 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:**______________________

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