(MEDS) What Medications do you take?

1_____2_____3_____

4_____5_____6_____

7_____8_____9_____

10_____11_____12_____

13_____14_____15_____

16_____17_____18_____

(ALLERGIES) DO YOU HAVE ALLERGIES TO ANY DRUGS? WHAT DO THE DRUG DO TO YOU?_____
_____

(SH)

Do you smoke or have you ever smoked? ___Yes ____No **If yes,** how many packs do you smoke a day?_____

If you smoked in the past how long ago did you quit?_____
_____

How much did you smoke a day before quitting? _____How long did you smoke before quitting?
_____

Do you drink alcohol or have you ever drinked? ____Yes ____No **If yes,** how much do you drink in a week _____**If you drinked in the past**, how much did you drink in a week and for how long?
_____

What is your educational level? _____
What is your profession? _____

(Family History): please check the appropriate response
FM MEM (Living)/(Deceased)(Current Age Or Age of death) Medical Problems

Mother:__L_____/____D_____(_____)_____
Father:__L_____/____D_____(_____)_____

PLEASE LISIT ANY MEDICAL PROBLEMS OF FAMILY MEMBERS BELOW

Sister(s):_____
_____

Brother(s):_____
_____

Children(s):_____
_____

(ROS) Y___/N___(FOR OFFICE USE ONLY)

(PREVIOUS TESTS)	**PLEASE CIRCLE ANY TEST YOU MAY HAVE HAD IN THE PAST (Approximate)**			
EMG: (Test of muscles and nerves)	yes	no	**date**___/___/_____	Where? _____
EEG: (Brain wave test)	yes	no	date___/___/_____	Where? _____
CAT scan (head or back)	yes	no	date___/___/_____	Where? _____
MRI scan (head or back)	yes	no	date___/___/_____	Where? _____
Recent blood tests	yes	no	date___/___/_____	Where? _____

PLEASE CICRCLE ALL THAT APPLIES ON ATTACHED SHEET ***(Please circle only those problems you frequently experience or have been treated for in the past.***

(PLEASE BRING COMPLETED QUESTIONARE WITH YOU WHEN YOU SEE THE DOCTOR)