

PACIFIC NORTHWEST NEUROLOGY
7502 LAKEWOOD DR, W #C7
LAKEWOOD, WA 98499

J. GREG ZOLTANI, M.D.
253-581-8151 FAX: 253-581-8152

PATIENT MEDICAL HISTORY

DATE: _____

NAME: _____ SSN: _____

ADDRESS: _____ CITY/ZIP: _____

PHONE: (H) _____ (C) _____ (W) _____

HEIGHT: _____ WEIGHT: _____ DATE OF BIRTH: _____

EMPLOYER: _____ FULL TIME () PART TIME () RETIRED () NOT WORKING ()

STUDENT: FULL TIME () PART TIME () NONE ()

SOCIAL:

MARITAL STATUS _____ SPOUSE'S NAME _____

SPOUSE'S DOB: _____

HEALTH HABITS:

DO YOU SMOKE? _____ HAVE YOU EVER SMOKED: _____

HOW MUCH _____ HOW MANY YEARS? _____

CAFFEINE INTAKE: COFFEE _____ TEA _____ COLA _____ CUPS/DAY _____

DO YOU DRINK ALCOHOL? _____

HAVE YOU EVER..... FELT NEED TO CUT DOWN ON ALCOHOL? YES NO
ANNOYED BY CRITICISM OF DRINKING? YES NO
HAD GUILTY FEELINGS ABOUT DRINKING? YES NO
TAKEN A MORNING EYE OPENER? YES NO

DO YOU EXERCISE REGULARLY? _____ HOW OFTEN _____

DESCRIBE OVERALL HEALTH: GOOD () FAIR () POOR ()

REVIEW OF PROBLEMS: (CIRCLE WHAT APPLIES TO YOU)

GENERAL: WT LOSS WT GAIN LOSS OF APPETITE FATIGUE WEAKNESS DEPRESSION
HIGH BLOOD PRESSURE

SLEEP: INSOMNIA SLEEPINESS

HEAD: HEADACHE MEMORY PROBLEMS

EYES: VISION CHANGE EYE PAIN

EARS: EARACHES HARD WAX TROUBLE HEARING

NOSE: CONGESTION NOSE BLEEDS SINUS PROBLEMS

THROAT: TROUBLE SWALLOWING SWELLING GOITER

LUNGS: COUGH WHEEZING SHORTNESS OF BREATH

HEART: CHEST PAIN/PRESSURE IRREGULAR HEARTBEATS

BREASTS: LUMP DISCHARGE TENDERNESS

ABDOMEN: HEARTBURN ABD. PAIN CONSTIPATION DIARRHEA

CHANGE IN STOOLS

KIDNEY/BLADDER: BLOOD IN URINE PAIN BURNING LOSS CONTROL

FEMALES: DISCHARGE IRREGULAR BLEEDING

MALES: DISCHARGE HEMIA IMPOTENCE

JOINT/MUSCLE: PAIN STIFFNESS DEFORMITY **WHERE:** _____

GLAND: DIABETES THYROID TROUBLE

OTHER (NOT LISTED): _____

HEADACHES:

Frequency: _____
Location: _____
Time of the day or night: _____
Duration: _____

HEALTH PREVENTION: (Write in year last done)

Tetanus _____ Flu shot _____ Pneumonia vaccine _____
TB test _____ Eye exam _____ Sigmoidoscopy _____
Rectal exam _____ PAP smear _____ Mammogram _____
Chest x-ray _____ EKG _____ Cholesterol _____

PAST MEDICAL HISTORY: (List operations, injuries and illnesses)

Problem	Year	Physician or Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT MEDICATIONS:

NAME	DOSAGE (MGS)	HOW MANY TIMES A DAY	HOW LONG
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES:

Are you allergic to any drugs or medications? _____
Any side effects to any drugs? _____
Name of drug and describe reaction: _____

FAMILY HISTORY:

Has any family member had (circle all that apply)

Diabetes Heart attack Breast cancer Stroke
Colon cancer Seizure (epilepsy) High blood pressure

Put in age or age of death and health for each family member:

Father _____ Mother _____
Brother _____ Sister _____
Brother _____ Sister _____
Brother _____ Sister _____
Child _____ Child _____
Child _____ Child _____
Child _____ Child _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

(Someone who does not live with you)

Name: _____
Relationship: _____
Phone: _____
Address: _____

