NISA
Neurology Institute
of San Antonio

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Medical Questionnaire

Patient Name: _____ Date Of Birth: _____

Medical History – **Check only current problems. Indicate age.**

General

YES NO

___ ___Fever
___ ___Weight Loss
___ ___Decreased Appetite
___ ___Excessive Fatigue

Eyes

YES NO

___ ___Wearing Glasses
Date Of Last Exam:_____
___ ___Glaucoma
___ ___Cataracts
___ ___Infections
___ ___Injuries

Ear, Nose, Throat, Mouth

YES NO

___ ___Wearing Hearing Aids
Date of last exam:_____
___ ___Nose Bleed
___ ___Congestion
___ ___Inability to smell
___ ___Sinus
___ ___Sinus headaches
___ ___Sore throat
___ ___Mouth sores
___ ___Hoarseness
___ ___Difficulty swallowing

Cardiovascular

YES NO

___ ___Chest pain/angina
Date Of Last EKG:_____
___ ___High Blood Pressure
___ ___Irregular pulse
___ ___Heart Murmur
___ ___High Cholesterol
___ ___Swollen hands/feet
___ ___Leg pain while walking
___ ___Pacemaker

Psychiatric

YES NO

___ ___Depression
___ ___Anxiety
___ ___Mental Illness
___ ___Sleeping difficulty

Endocrine

YES NO

___ ___Diabetes
___ ___Thyroid Disease
___ ___Hormone problem
___ ___Increased thirst/urination
___ ___Increased appetite

Respiratory

YES NO

___ ___Asthma
___ ___Emphysema
___ ___Bronchitis
___ ___Chronic cough
___ ___Shortness of breath
___ ___Pneumonia
___ ___Bloody Sputum
___ ___Lung Cancer
___ ___TB

Gastrointestinal

YES NO

___ ___Persistent
___ ___Nausea/vomiting
___ ___Blood in vomit
___ ___Heartburn
___ ___Gallbladder problems
___ ___Hernia
___ ___Abdominal pain
___ ___Ulcer/gastritis
___ ___Change in bowel habits
___ ___Liver disease
___ ___Jaundice
___ ___Diverticulitis
___ ___IBS/Colitis
___ ___Hemorrhoids
___ ___Colon cancer

Genitourinary

YES NO

___ ___Urinary tract infection
___ ___Painful urination
___ ___Blood in urine
___ ___Loss of bladder control
___ ___Kidney stones
___ ___Sexually transmitted disease

MALES

___ ___Prostate problems

FEMALES

___ ___Menstrual flow irregular
___ ___Menopause
___ ___Uterine/cervical cancer
___ ___Breast pain
___ ___Birth control
Method_____
Date of last PAP _____
Date of last mammogram _____

Allergic/Immunologic

YES NO

___ ___Food allergies
___ ___Inhalant Allergies
___ ___Drug Allergies

Hematology/Lymphatic

YES NO

___ ___Anemia
___ ___Bleeding tendencies
___ ___Phlebitis
___ ___Persistent swollen glands or lymph nodes
___ ___Blood transfusion
When? _____

Musculoskeletal

YES NO

___ ___Back/neck pain
___ ___Arm/leg pain
___ ___Joint pain/swelling
___ ___Arthritis
___ ___Broken bones
___ ___Osteoporosis

Integumentary

YES NO

___ ___Skin disease/type
___ ___Rash/where

Neurological

YES NO

___ ___Fainting/blackout spells
___ ___Seizures
___ ___Memory problems
___ ___Disorientation/confused
___ ___Concentration problems
___ ___Difficulty with speech
___ ___Double/blurred visions
___ ___Facial weakness
___ ___Headaches
___ ___Strokes
___ ___Muscle weakness
___ ___Numbness/tingling
___ ___Tremors/hand shaking
___ ___Eat salty foods
___ ___Add salt to your food
___ ___Eat out frequently
___ ___Drink coffee, tea, soda
How much? _____
___ ___Drink alcoholic drinks
How much? _____
___ ___Smoke cigarettes
How much? _____
___ ___Exercise regularly
___ ___Other medical problems

_____
_____
_____

___ ___Living will
___ ___Advanced Directive Power of Attorney