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

Hematology/Lymphatic

YES NO
- ☐ ☐ Anemia
- ☐ ☐ Bleeding tendencies
- ☐ ☐ Phlebitis
- ☐ ☐ Persistent swollen glands/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