NISA
Neurology Institute
of San Antonio

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Medical Questionnaire

Date:_____

Patient's Name:_____

Patients Date of Birth:_____

Reason For Visit:_____

Surgeries	**Year**	**Complication**

Hospitalizations	**Year**	**Complication**

Have you ever had problems with Anesthesia? **YES** ☐ **NO** ☐

CT/MRI Studies	**Location**	**Date**	**Doctor Ordering**

Family History – Check if any blood relative has had any of the following. Indicate which relative.

☐ **Diabetes**	☐ **Asthma**	☐ **Osteoporosis**	**Note:**_____
☐ **Heart Disease**	☐ **Migraines**	☐ **Anemia**	_____
☐ **Seizures**	☐ **Alcoholism**	☐ **Thyroid Problem**	_____
☐ **Allergies**	☐ **Cancer**	☐ **High Blood Pressure**	_____
☐ **Meniere's Disease**	☐ **Arthritis**	☐ **Mental Illness**	_____
☐ **Stroke**	☐ **Glaucoma**	☐ **High Cholesterol**	_____