RUTGERS
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Department of Neurology
Heath Questionnaire & Review of Systems

*** **Note to Patient: This form is a part of your Medical Record. Please complete both sides of Questionnaire*****

NAME: _____ DATE: _____

D.O.B: _____ AGE: _____

Are you **RIGHT** handed or **LEFT** handed? (Circle one)
Reason for visit: _____

_____

Past History: List any Medical Problems you are treated for:

_____

_____

List of any surgeries you had:

_____

_____

Medications : (List **ALL** medications you taking and the amount)

_____

_____

Allergies: (List **ALL** medications to which you are allergic-Examples: *Sulfa, Penicillin, Codeine, Aspirin*)
(List any Environmental and Food allergies)

_____

Family History: (Blood Relative ONLY-List Conditions)

_____

Social History: _____ Married _____ Single _____ Divorced _____ Widowed
How many years of formal education have you completed? _____
Present Employment status: ____Full-time ____ Part-time ____ Unemployed ____ Retired ____ Disabled
What is/Was your occupation? _____
Did you ever smoke or use tobacco? _____ No _____ Yes
If yes, packs per day: _____ For how many years?: _____
Did you quit? _____ If YES, when? _____
How frequently do you consume alcoholic beverages?
_____Never _____1-7 Drinks/Week _____ More than 7 drinks/week

Have you traveled outside of the USA in the last 12 months? _____ No_____ Yes

SYSTEMIC SYMPTONS:		**PHYSICIAN NOTE:**
Ear/Nose/Throat Problems	_____Yes_____ No	_____
Fever	_____Yes_____ No	_____
Weight Loss (Unexplained)	_____Yes_____ No	_____
Severe	_____Yes_____ No	_____
CARDIOVASCULAR:		
Presence of Chest Pain or Pressure	_____Yes_____ No	_____
Irregular Heart beat	_____Yes_____ No	_____
Dizziness/fainting	_____Yes_____ No	_____
Swelling of the Feet	_____Yes_____ No	_____
Blood Clots in the Legs or Lungs	_____Yes_____ No	_____
RESPIRATORY:		
Cough	_____Yes_____ No	_____
Difficulty breathing	_____Yes_____ No	_____
GASTROINTESTINAL:		
Nausea or vomiting	_____Yes_____ No	_____
Blood in Stool	_____Yes_____ No	_____
Difficulty in swallowing	_____Yes_____ No	_____
Change in Bowel Habits	_____Yes_____ No	_____
Loss of Appetite	_____Yes_____ No	_____
GENITOURINARY:		
Urinary Problems	_____Yes_____ No	_____
Problems with Sexual function	_____Yes_____ No	_____
MUSCULOSKELETAL:		
Joint Stiffness or Swelling	_____Yes_____ No	_____
Muscular Pain/Cramps	_____Yes_____ No	_____
Back Pain	_____Yes_____ No	_____
Varicose Veins	_____Yes_____ No	_____
Skin Problems	_____Yes_____ No	_____
PSYCHIATRIC:		
Depression	_____Yes_____ No	_____
Agitation	_____Yes_____ No	_____
Anxiety/Nervous Disorder	_____Yes_____ No	_____
Memory Problems	_____Yes_____ No	_____
ENDOCRINE:		
Excessive Urination	_____Yes_____ No	_____
Excessive Thirst	_____Yes_____ No	_____
Cold/Heat intolerance	_____Yes_____ No	_____
For **Women Only**-Onset of Menopause	_____Yes_____ No	_____
HEMATOLOGIC/LYMPHATIC:		
Bleeding Problems or Easy Bruising	_____Yes_____ No	_____

_____ _____

(Signature of Individual completing form) (Relationship to Patient)

I have reviewed this form with the Patient: _____ Date: _____

(Physician Signature)