GRAND LAKE NEUROLOGICAL CENTER™
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

NEW PATIENT HISTORY

Patient Name: _____ Date of Birth: _____

Please list any other allergies you may have: _____

_____

_____

YOUR MEDICAL HISTORY – Please check if you have any of these diagnoses:

☐ Dementia ☐ Epilepsy
☐ Migraines ☐ Stroke
Other medical problems: _____

_____

PROVIDERS
Please list information for any other physicians you currently see: (*ex: Dr. Smith - Urologist, Celina, OH*)

_____

_____

_____

FAMILY MEDICAL HISTORY – please indicate who has this in your family (Mother, Father, Brother, Sister, Paternal Grandparent, Maternal Grandparent, Children)

Arthritis _____
Bleeding Disorder _____
Brain Cancer _____
Dementia _____
Diabetes _____
Heart Disease _____
High Blood Pressure _____
Liver Disease _____
Mental Illness _____
MS _____
Parkinsons _____
Seizures _____
Stroke _____
Tremor _____
Alcohol Abuse _____
Drug Abuse _____
Birth Defects _____
Genetic Disorders _____
Migraines _____
Aneurysm_____
Other _____

SURGICAL HISTORY

Please list all of your surgeries and the date they were done.

_____

_____

_____

_____

_____

YOUR SOCIAL HISTORY

Marital Status _____ Spouse Name: _____

Culture/Language _____

Living situation ☐ alone ☐ with spouse/partner ☐ with family ☐ Group Home ☐ Nursing Home

Occupation _____

Do you drink alcohol? ☐ YES ☐ NO

How much alcohol do you consume a week? _____

Do you smoke? ☐ YES ☐ NO

How much do you smoke? _____

Are you a former smoker? ☐ YES ☐ NO

How long did you smoke? _____

Do you have any tobacco smoke exposure? ☐ YES ☐ NO

Illicit drug use? ☐ YES ☐ NO

How much caffeine do you drink daily? _____

Do you have any pets? ☐ Yes ☐ No What type? _____

What countries have you traveled to in the past 6 months? _____

PHARMACY_____**LOCATION**_____

YOUR MEDICATIONS

Please List or attach a copy of all of your current medications with dosages.

MEDICATION	DOSAGE