Stephen R. Burton, MD

Medical History

Name: _____ Date of Birth: _____ Ht:_____ Wt: _____

Reason you were sent to a Neurologist: _____

_____

Drug Allergies: _____

Past Medical History/Surgeries: _____

_____

_____

Social History: Please indicate the amount of use of the following where applicable:

Alcohol _____
Coffee/Caffeine _____
Recreational Drugs_____
Other _____

Vascular Risk Factors: Check the applicable factors:

Smoking _____
High blood pressure _____
Elevated cholesterol _____
Diabetes _____

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Constitutional Symptoms			**Gastrointestinal**			**Musculoskeletal**		
Fever	Y	N	Abdominal pain	Y	N	Arthritis	Y	N
Night sweats	Y	N	Nausea/vomiting	Y	N	Neck pain	Y	N
Weight change	Y	N	**Cancer/Tumor**			Back pain	Y	N
Eyes			Location: _____			**Ear/Nose/Throat**		
Double vision	Y	N	_____			Sinus trouble	Y	N
Loss of vision	Y	N	_____			Deafness	Y	N
Glaucoma	Y	N	**Urologic**			**Respiratory**		
Allergy/Immunology			Incontinence	Y	N	Shortness of breath	Y	N
HIV/AIDS	Y	N	Kidney stones	Y	N	Frequent cough	Y	N
Hepatitis	Y	N	**Cardiovascular**			**Psychological**		
Asthma	Y	N	Angina/Heart disease	Y	N	Depression	Y	N
Endocrine			Pacemaker	Y	N	Osteoporosis	Y	N
Thyroid disease	Y	N	Irregular heart beat	Y	N	Anxiety	Y	N
			Skin			**Hematologic**		
			Birth marks	Y	N	Blood clotting	Y	N
			Skin rash	Y	N			

Other Problems: _____

_____

Family History: Does any member of your family have any of the following? Circle any applicable.
Stroke, Heart disease, Epilepsy, Multiple Sclerosis, Parkinson, Alzheimer's, Migraine, Other: _____

_____

Medications:

_____ _____
_____ _____
_____ _____
_____
_____
_____
_____
_____

Retail Pharmacy: _____
Mail Order Pharmacy: _____

Have you received the Flu Vaccine this year?
_____No _____Yes, if so when _____