Hood River
NEUROLOGY

Patient Information & Medical History

Patient Information

First Name_____ Last Name_____ DOB_____

Gender_____ Email_____

Address_____ City_____ State_____

Zip Code_____

Home Phone_____ Cell Phone_____

Emergency Contact

Name_____

Relationship_____

Phone_____

Insurance Information

Insurance Company _____

Group number_____ ID number_____

Social Security Number_____

Primary Care Physician_____

Referred By_____

Pharmacy_____

Reason for Visit _____

Drug Allergies_____

Medications _____

_____

Past Medical History_____

_____

Conditions

- Stroke
- Diabetes
- High Blood Pressure
- Heart Disease
- Seizures
- Migraine
- Bleeding disorder
- Sleep apnea
- Liver disease
- Kidney disease
- Lung disease
- Gastric ulcer
- Depression
- Anxiety
- Cancer

Do you smoke?_____ Caffeine intake_____

Have you had an MRI or CT scan performed?_____