Martin H. Wagner, M.D.

Medical History

Name: ____ Date of Birth:___________ Age:_______

Name of primary care physician ____ Phone ___________

Name of physician who referred you to this office _________________________ Phone ___________

What is the main reason for your visit today? ____

Names of any other neurologists seen for this problem ______________________________________

Height _________ Weight ________ Are you right handed or left handed?

Alcohol consumption: Never/Rarely/Moderate/Daily Tobacco use: Never/Rarely/Moderate/Daily

Street drug use: Never/Rarely/Moderate/Daily Are you pregnant: Yes/No

Patient Medical History: Check all medical problems that apply to you:

Anemia
Asthma
B12 deficiency
Balance difficulty
Bipolar affective disorder
Bruise easily
Cancer
Carpal tunnel syndrome
Change in appetite
Chest pain
Choke easily
Chronic cough
Chronic daily headache
Chronic fatigue
Cluster headache
Congestive heart failure
COPD
Deafness
Dementia
Depression
Diabetes
Difficulty expressing yourself
Difficulty understanding speech
Double vision
Eye pain
Fainting spells
Falls
Fibromyalgia
Head injury
Heart attack
Heart bypass surgery
Heart valve surgery
High blood pressure
High cholesterol
Insomnia
Irregular pulse
Kidney disease
Leg pain when walking
Liver disease
Low back pain
Lupus
Memory difficulty
Meningitis
Migraine
Multiple sclerosis
Narcolepsy
Neck pain
Neuropathy
Numb or painful feet
Numb or painful hands
Panic disorder
Parkinson's disease
Peripheral artery disease
Recent suicidal thoughts
Recent weight gain
Recent weight loss
Restless leg syndrome
Rheumatoid arthritis
Ringing in ears
Ruptured disc
Schizophrenia
Seizures
Shortness of breath
Sleep apnea
Slurred speech
Spine injury
Stomach or intestinal ulcer
Stroke
Thyroid disorder
Tremor
Urinary incontinence
Vertigo
Vision loss

MEDICATION ALLERGIES ____

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 Medical History, Continued

Name of Patient ______________________________ Today's date ____________

Hospital admissions in last five years:

Date	Name of Hospital	Reason for admission

Family Medical History

	Age Current Illness/Conditions	or Cause of Death and Age
Father		
Mother		
Brother/sister		
Brother/sister		
Brother/sister		

Medical Testing within the last five years (e.g. CT, MRI, EEG, EMG, Carotid Doppler, Sleep study, EKG, Holter monitor)

Date	Name of test	Where it was done	Date	Name of test	Where it was done

Communicable Diseases: Have you ever been diagnosed with:

Hepatitis C Yes/No If yes, when? ____________

Tuberculosis Yes/No If yes, when? ____________

Aids/HIV Yes/No If yes, when? ____________

Any other communicable disease? ______________________________ When?____________

Signature ______________________________ Date ____________