GEORGIA NEUROLOGY AND SLEEP MEDICINE ASSOCIATES

NAME_____ DATE_____

PAST HISTORY:_____

SURGERIES:_____

MAJOR MEDICAL PROBLEMS:	NO	YES	ALLERGIES_____
High Blood Pressure	_____	_____	_____
Diabetes	_____	_____	_____
Stroke	_____	_____	_____
Heart Disease	_____	_____	_____

PLEASE LIST ALL MEDICATIONS (WITH DOSAGES IF POSSIBLE)

_____

_____

_____

_____

Do you smoke?_____How much per day?_____How long?_____

What is your average alcohol consumption per week?_____

FAMILY HISTORY	NO	YES
High Blood Pressure	_____	_____
Diabetes	_____	_____
Stroke	_____	_____
Heart Disease	_____	_____

Other_____

SOCIAL HISTORY:

Marital Status _____

Occupation_____ Previous Occupation_____

Spouse's Occupation (Last 5 years)_____

Do you have children?_____What are their ages?_____

Primary Care Physician_____