

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 _____