Triangle Neurology and Sleep Lab, PA
Laura Jozewicz, MD
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Ph. 919.845.2580 Fax 919.845.2581

New Patient History Form – Page 1

Name :_________________________________ Age:________ Sex:___________ Race: W B H A

Right Handed __________ Left Handed __________

Present complaints or symptoms (list separately)

____
____
____
____

Review of symptoms (circle all that apply):

Systematic	HEENT	GI	GU	Pulmonary
fever	headache	heartburn	sexual dysfunction	cough
weight loss/gain_ lbs	sinus	stomach pain	urinary tract infection	shortness of breath
fatigue	ringing of ears	bowel changes	urinary complaints	wheezing
appetite incr/decr.	snoring	cancer	kidney stones	
depression	excess sleepiness	lever problems	prostate problems	
		gallbladder	vaginal discharge	
			menstrual changes	

Muscle Joint	CNS	Endocrine	Blood	CVS
joint pain	dizziness	thyroid problems	anemia	chest pain
muscle aches	leg/hand numbness		lymph node swelling	heart palpitations
weakness	leg/hand weakness		bleeding tendency	calf pain
backache	sleep problems			
mouth sores	headache			
	problems with balance			
	difficulty walking			
	“spells”			

Past medical history

Diabetes___________ Hypertension______________ High Cholesterol___________
Thyroid problems_____ Heart Attack/failure _________ Stroke ___________________
Emphysema/Asthma____ Arthritis___________________ Peptic Ulcer/Hiatal Henia_____

Prior Surgeries (give year)

Hysterectomy________________________ Gallbladder Surgery_____________________
Tonsillectomy/Adenectomy____________ Appendectomy_________________________
By-Pass(Heart/Femoral)_______________ Laminectomy (lumbal/cervical)__________
Other______________________________ Mastectomy____________________________

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New Patient History Form – Page 2

Medications
Please list all medications below (prescriptions and over-the-counter)

	Name	Dose & Interval	Who Prescribed
1.			
2.			
3.			
4.			
5.			
6.			

Allergies
Medications
Shrimp/Seafood
IVP Dye
Other

Social History
Marital Status: Married Single Divorced Separated
Children ________________________ Age ______________________

	How many years?	How many per day?	If quit, when?
Smoking			
Alcohol			
Other Drugs			

Occupation
Present ___________________
Retired ___________________
Disabled __________________

Family History
High Cholesterol __________________________
Cancer __________________________
Heart condition __________________________
Lupus __________________________
Diabetes __________________________
Thyroid __________________________
Alzheimer Disease __________________________
Headache/Migraine __________________________
Multiple Sclerosis __________________________
Stroke __________________________
Parkinson's__________________________
Seizures __________________________
Rheumatoid Arthritis __________________________

Primary Physician
Name ____________________________ Telephone ________________ Last seen ______________

Signature ____ Date ______________________________