| MRN | | |
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Baylor Scott & White Neurology - Plano

Neurology Health History Questionnaire

4708 Alliance Blvd. Suite 550, Plano, TX 75093

| Dr. Michael P. Kellam, M.D. O Dr. Wei lang, M.D. | O Dr. Avesh Raja Verma, M.D. | | | |
|---|----------------------------------|--|--|--|
| Dr. Jiaqi Yao, M.D. O Dr. Jonatha | an Lauritsen, D.O. | | | |
| Name: | DOB: | | | |
| Occupation: | | | | |
| Who referred you to a Neurologist? | PCP: | | | |
| What is your dominant hand? Left Right Ambidextrous | | | | |
| What condition or symptoms are you being seen for today? | | | | |
| | | | | |
| How long has this been a problem? | | | | |
| What makes your symptoms worse? | | | | |
| What makes your symptoms better? | | | | |
| Do your symptoms occur at a certain time of day? | | | | |
| On a scale of 1-10, with 10 being the worst, how would you rat | e the severity of your symptoms? | | | |
| What, if any, testing have you had done for this condition? ☐ MRI ☐ CT ☐ Lab/Blood ☐ EEG ☐ EMG ☐ Lumbar Puncture ☐ Other: ☐ N/A | | | | |
| Date and Location of previous testing: | | | | |
| Have you been treated for this condition? ☐ Yes ☐ No If YES, what was the treatment? | | | | |
| | | | | |
| Have you previously seen a Neurologist? ☐ Yes ☐ No If YES, who? | | | | |
| What were you seen for? | | | | |
| List any previous surgeries, along with dates: | | | | |
| | | | | |
| | | | | |
| Who should we contact in case of emergency? Name: | | | | |
| Relationship to you: Phone Num | ıber: | | | |



| Where do you live? \square Single-sto | ory house 🏻 Two-story house 🕻 | ☐ Apartment ☐ Assisted Living | | | |
|---|-------------------------------|-------------------------------|--|--|--|
| Who do you live with? | | Do you drive? 🗆 Yes 🗆 No | | | |
| Do you drink alcohol? ☐ Yes ☐ N | lo How often? | How many drinks? | | | |
| Do you use tobacco? ☐ Yes ☐ N | o If YES: ☐ Cigarettes ☐ Va | pe Pen 🛚 Smokeless Tobacco | | | |
| How much? | Age Started: | Date Quit? | | | |
| Do you use any illicit drugs? ☐ Yes ☐ No If YES: ☐ Marijuana ☐ Cocaine ☐ Methamphetamines | | | | | |
| | ☐ Other: | | | | |
| What are your hobbies? | | | | | |
| Family History (list relationship): | ☐ Alzheimer's Disease | | | | |
| ☐Autoimmune Disease | 🗖 Brain Cancer | □ Breast Cancer | | | |
| ☐ Cerebral Palsy | Depression | | | | |
| ☐ Migraines | _ ☐ Muscular Dystrophy | 🗆 Seizures | | | |
| ☐ Parkinson's Disease | 🗆 Myasthenia Gravis _ | □ Stroke | | | |
| ☐ Muscular Sclerosis | 🗆 ALS | | | | |
| ☐ Other | | | | | |
| Medication Allergies: | | | | | |
| Current Medications: Please list all prescription AND over-the-counter medications and supplements. Name of medication, dose, and frequency. | | | | | |
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