PATIENT FOCUSED
— NEUROLOGY —

"Patient Care is our FOCUS."

Medication List Update/Health History Questionnaire

Patient Name: (Last) _____ (First) _____ DOB: _____ Today's Date: _____

Please list your doctors (starting with the doctor who referred you here, if any)

Doctor:	**Specialty:**
_____	_____
_____	_____
_____	_____

CHIEF COMPLAINT

What is the reason for your visit today?

PERSONAL HEALTH HISTORY

List Any Medical Problems/Current Illnesses

List Your Prescription and Over-the-Counter Medication

Name the Medication	*Dosage*	*Frequency*	*Name the Medication*	*Dosage*	*Frequency*
1.			**6.**		
2.			**7.**		
3.			**8.**		
4.			**9.**		
5.			**10.**		

Are you allergic to any medication? No Yes (If yes, please list medication and the kind of reaction)

Name the Medication	*Allergic Reaction*	*Name the Medication*	*Allergic Reaction*
1.		**5.**	
2.		**6.**	
3.		**7.**	
4.		**8.**	