Patient History Form

MR#:_____ Date:_____

Name:_____

DOB:_____ Gender: □ Male □ Female

Who completed this form? □ Self □ Parent □ Spouse/Family Member □ Guardian □ Other

1. Indicate whether you have ever had a medial problem or surgery related to each of the following.
Indicate "no problem" when appropriate. More than one answer may apply.

	No Problem	Medical Problem	Surgery		No Problem	Medical Problem	Surgery
Eyes	□	□	□	Pancreas	□	□	□
Ears	□	□	□	Hernia	□	□	□
Nose	□	□	□	Kidneys	□	□	□
Sinuses	□	□	□	Bladder	□	□	□
Tonsils	□	□	□	Bones	□	□	□
Thyroid/Parathyroid	□	□	□	Joints	□	□	□
Heart Problems:				Muscles	□	□	□
Heart Attack	□	□	□	Back	□	□	□
Heart Valves	□	□	□	Neck	□	□	□
Abnormal heart rhythm	□	□	□	Spine	□	□	□
Narrowed coronary arteries	□	□	□	Brain	□	□	□
Other	□	□	□	Skin	□	□	□
Arteries (head, arms, legs, etc.)	□	□	□	Breasts	□	□	□
Veins or blood clots in veins	□	□	□	**Females:**			
Lungs	□	□	□	Uterus	□	□	□
Esophagus	□	□	□	Ovaries	□	□	□
Stomach (ulcer)	□	□	□	Fallopian tubes	□	□	□
Bowel (intestine or rectum)	□	□	□	Hysterectomy	□	□	□
Appendix	□	□	□	Other	□	□	□
Lymph nodes	□	□	□	**Males:**			
Spleen	□	□	□	Prostate	□	□	□
Liver	□	□	□	Penis	□	□	□
Gallbladder	□	□	□	Testicles	□	□	□
				Vasectomy	□	□	□
				Other	□	□	□

Family History

If known, complete the following information about your blood relatives (include children).

2. Are you adopted? □ No □ Yes

3. Father □ Don't know
□ Alive
□ Deceased → age at death: _____

4. Mother □ Don't know
□ Alive
□ Deceased → age at death: _____

5. Brothers
Number Alive: _____
Number Deceased: _____
Don't Know: □

6. Sisters
Number Alive: _____
Number Deceased: _____
Don't Know: □

7. Sons
Number Alive: _____
Number Deceased: _____
Don't Know: □

8. Daughters
Number Alive: _____
Number Deceased: _____
Don't Know: □

CONTINUE ON REVERSE SIDE

Check the appropriate boxes to identify all illnesses or conditions which you know have occurred in you or your blood relatives. Indicate "NONE" if you are unsure.

	Self	Father	Mother	Brothers	Sisters	Sons	Daughters	Grandparents	None
Cancer	□	□	□	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□	□	□
Asthma	□	□	□	□	□	□	□	□	□
Eczema/Psoriasis	□	□	□	□	□	□	□	□	□
Migraine headaches	□	□	□	□	□	□	□	□	□
Seizure disorder	□	□	□	□	□	□	□	□	□
Stroke/TIA	□	□	□	□	□	□	□	□	□
High cholesterol	□	□	□	□	□	□	□	□	□
Abnormal bleeding	□	□	□	□	□	□	□	□	□
High or low white count	□	□	□	□	□	□	□	□	□
High blood pressure	□	□	□	□	□	□	□	□	□
Anemia	□	□	□	□	□	□	□	□	□
Liver disease	□	□	□	□	□	□	□	□	□
Hepatitis	□	□	□	□	□	□	□	□	□
Arthritis	□	□	□	□	□	□	□	□	□
Osteoporosis	□	□	□	□	□	□	□	□	□
Alcohol abuse	□	□	□	□	□	□	□	□	□
Recreational/Street drug use	□	□	□	□	□	□	□	□	□
Sexually transmitted disease	□	□	□	□	□	□	□	□	□
Depression	□	□	□	□	□	□	□	□	□
Other Psychiatric disease	□	□	□	□	□	□	□	□	□
Suicide (or attempted suicide)	□	□	□	□	□	□	□	□	□
Tuberculosis	□	□	□	□	□	□	□	□	□
Anesthesia complication	□	□	□	□	□	□	□	□	□
Genetic disorder	□	□	□	□	□	□	□	□	□
Dementia	□	□	□	□	□	□	□	□	□
Parkinson's disease	□	□	□	□	□	□	□	□	□
Other	□	□	□	□	□	□	□	□	□

Patient Signature_____ Date:_____

Physician Signature_____Date:_____

Read and reviewed with patient in detail

The Movement Disorder Clinic of Oklahoma Kevin J. Klos, MD