BREA Stroke Center Health HX

Name:_____ DOB:_____

Reason for visit: Headaches____ Stroke____ Epilepsy____ Other:_____

Primary Care Provider:_____ Referring Provider:_____

Past Medical History:

High Blood Pressure__ High Cholesterol__Liver Disease__Diabetes__ Thyroid Problems__

Kidney Disease__Heart Attack/Bypass Surgery__ Heart Failure__Heart Murmur__Mitral Valve

Prolapse__Stroke__ Seizures/Epilepsy__Stomach Problems__Intestinal Problems__Reflux

Disease__Glaucoma__Psychiatric Illness__Arthritis__Cancer__

Other_____

Family History:

Mother:_____

Father:_____

Social History: *Please indicate current or former use for each of the following:

Alcohol use:_____ Substance Use:_____Tabacco Use:_____

Lives with:_____ Occupation:_____

Hospitalizations and/or Surgeries_____

_____

_____

_____

List any drug allergies_____

_____

Are you allergic to Latex?_____

Preferred Pharmacy:_____

List all current medications: *Please include dosage and directions

_____ _____

_____ _____

_____ _____

_____ _____

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