

Alliance Neurology
Neurology Health History Questionnaire
4716 Alliance Blvd – Suite 700, Plano, TX 75093
Dr Michael P. Kellam, M.D.
Dr Aberto Santos, M.D.
Dr Avesh Raja Verma, M.D.

Name: _____ DOB: _____

Occupation: _____ Marital Status: _____

Who referred you to a Neurologist?: _____ Name of Primary Care Physician: _____

What condition or symptoms are you being seen for today? _____

What types of testing have you had done for this condition? MRI CT Lab/Blood Other: _____

When and where did you have the testing? _____

List any problems with the following: _____

Head: _____ Stomach: _____

Eyes, Ears, Nose, Throat: _____ Intestines: _____

Neck or Back: _____ Liver/Gallbladder: _____

Heart: _____ Genitalia: _____

Lungs: _____ Bladder/Kidneys: _____

Bones/Joints: _____ Females: date of last period: _____

Do you Smoke? No Yes Packs per day? _____ Age started: _____ Date quit: _____

Do you drink? No Yes How much? _____

Family History of Neurological Diseases No Yes

Is yes, please explain: _____

Have you had surgery in the last 10 years No Yes

Type of surgery: _____ Date: _____ Hospital: _____

Medication Allergies: _____

Daily Medications Including OTC (over the counter): _____
