

**Upstate Neurology Consultants, LLP  
Health Questionnaire – To Be Completed By The Patient**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Insurance: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Other Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

Surgeries: \_\_\_\_\_

\_\_\_\_\_

**Family History**

Condition	Self	Father	Mother	Grandparents	Siblings	Children
Coronary artery disease						
Atrial Fibrillation						
Congestive Heart Failure						
Hypertension						
Asthma						
Obstructive Lung Disease						
Gastrointestinal						
Kidney Disease						
High Cholesterol						
Thyroid disorder						
Diabetes						
Arthritis						
Depression						
Anxiety Disorder						
Autoimmune Disease						
Migraine						
Epilepsy/Seizures						
Tremor						
Stroke						
Neuromuscular Disease						
Neuropathy						
Dementia						
Fainting						
Kidney Stones						
Parkinson's disease						
Restless Legs Syndrome						
Cancer						
Heart Valve Surgery						

Do you smoke?  Yes  No How much? \_\_\_\_\_

Do you drink?  Yes  No How much? \_\_\_\_\_

Are you a substance abuser?  Yes  No Which substance? \_\_\_\_\_

Are you:  Right-handed  Left-handed

Occupation: \_\_\_\_\_

Who do you live with? \_\_\_\_\_