BAHAMAS NEUROLOGICAL CENTER, INC.
At the Parthenon, West Street
P.O. Box CR-54258 Nassau, Bahamas
Phone (242) 322-8763 • Fax (242) 322-8764

Health history questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Date: _____ **Completed By (relationship to patient):** _____

Name: _____ **Sex**: □ M □ F **D.O.B.**: _____

Marital Status: □ Single; □ Partnered; □ Separated; □ Divorced; □ Widowed **# of Children:** _____

Employer: _____

Occupation: _____

Years at Job: _____ **Shift Worker:** _____

Exercise:

□ Sedentary *(No exercise)*
□ Mild exercises *(i.e., climb stairs, walk 3 blocks, golf)*
□ Occasional vigorous exercise *(i.e., work/recreation, less than 4x / week for 30 min.)*
□ Regular vigorous exercise *(i.e., work or recreation 4x / week for 30 min.)*

Alcohol

Do you drink alcohol? □ Yes □ No
If yes, what kind? _____ How many drinks per week? _____

Tobacco

Do you use tobacco? □ Yes □ No # of years: _____ Year quit: _____
Cigarettes _____ pks. /day; Chew _____ #/day; Pipe _____#/day; Cigars _____#/day

Drugs

Do you currently use recreational or street drugs? □ Yes □ No

Childhood illness:

_____
_____
_____
_____

List your prescribed drugs and over-the-counter medications, such as vitamins and inhalers:

Drug Name	Dosage &Frequency

List al known allergies to medications:

Drug Name	Reaction You Had

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Review of Medical Symptoms:
Check if you have, or have had any symptoms in the following areas to a significant degree, and briefly explain:

☐	Heart Disease	☐	Allergies	☐	Pneumonia
☐	Heart Attack	☐	Heartburn	☐	Asthma
☐	Strokes	☐	Cancer	☐	Bronchitis
☐	Meningitis	☐	Hemophilia (bleeder)	☐	Tuberculosis
☐	Epilepsy/Seizures	☐	Prostate Disease	☐	Urinary Problems
☐	Fainting/Blackouts	☐	Kidney Disease	☐	Impotence
☐	Dizziness	☐	Ulcers	☐	Venereal Disease
☐	Headaches	☐	Hernia	☐	Muscle Cramps
☐	Eye Disease	☐	Gout	☐	Abnormal Sensations
☐	High Blood Pressure	☐	Mental Problems/Psychiatric Disorder	☐	Back Pain
☐	Low Blood Pressure	☐	Depression	☐	Arthritis
☐	Hearing Impairment	☐	Dementia	☐	Gait Disturbance
☐	Ringing of the Ears	☐	Other:		

Hospitalization & Surgical History:

_____
_____
_____
_____

Family Health History

List which biological relatives (mother, father, aunts, uncles, sibling, grandparents, children) have any of the following diseases/disorders (please list the age when they were diagnosed):

Asthma	_____	High Cholesterol	_____
Bleeding Disorder	_____	Hypertension	_____
Epilepsy/Seizures	_____	Intestine Disorder	_____
Cancer	_____	Kidney Disorder	_____
Depression	_____	Mental Illness	_____
Diabetes	_____	Neurological Disorder	_____
Drug/Alcohol Abuse	_____	Premature Death	_____
Eating Disorder	_____	Strokes	_____
Gynecologic Problems	_____	Suicide Attempt	_____
Glaucoma	_____	Thyroid Disease	_____
Heart Disease	_____	Other	_____

Comments:

_____
_____
_____
_____

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Infant/Child Health History Supplement

Pediatrician/General Physician: _____

Age 0 - 5 years:

Delivery type: □ Vaginal; □ C-Section □ Single or □ Multiple Birth Premature: □ Yes; □ No

Length of Pregnancy: _____ (weeks) Birth Weight: _____ (lbs) Head Circumference: _____ (in)

Has the patient had any symptoms in the following areas to a significant degree, and briefly explain:

- ☐ Birth Complication
- ☐ Developmental Problems
- ☐ Speech & Language Delay
- ☐ Mental Delay
- ☐ Plays well with others
- ☐ Day Care
- ☐ Immunizations up to date
- ☐ Reactions to Immunization

Comments:

_____

_____

_____

Please state the age patient completed the following by his/herself:

Rolled over	_____	Talked	_____
Sat up	_____	Helps feed his/herself	_____
Stood up	_____	Helps dress his/herself	_____
Walked	_____		

Age 6 - 18 years:

School: _____ Grade: _____

Grade Average:□ A, □ B, □ C, □ D, □ Special Education, □ Advanced, □ Failing

Sports: _____

- ☐ Emotional Issues
- ☐ Sexually Active

Comments:

_____

_____

_____