Traci A. Purath, M.D.

Name: _____ Date: _____

Reason for referral: _____

Current occupation or school attending: _____

Allergies: _____

Previous illnesses and surgeries: _____

_____

Do you have any of the following symptoms or problems? Circle Yes or No.

Fever/night sweats	Yes / No	Shortness of breath/cough	Yes / No	Muscle pain or weakness	Yes / No
Weight loss	Yes / No	Stomach pain/ulcer	Yes / No	Numbness	Yes / No
Loss of consciousness	Yes / No	Bowel or bladder problems	Yes / No	Nervous/mental disorder	Yes / No
Headache	Yes / No	Seizures	Yes / No	Depression	Yes / No
Visual disturbance	Yes / No	Joint pain or swelling	Yes / No	Diabetes	Yes / No
Hearing loss	Yes / No	Dizziness	Yes / No	High blood pressure	Yes / No
Chest pain	Yes / No	Back pain	Yes / No	Memory problems	Yes / No

List your current medications along with strength and directions (include over the counter and vitamins): _____

_____

What questions do you have for the doctor today? _____

_____

_____

Do you have any physical limitations? Yes / No

If yes, explain: _____

_____

Is there a family history of?

Seizures	Yes / No	Heart disease	Yes / No
Headache	Yes / No	Psychiatric illness	Yes / No
Stroke	Yes / No	Cancer	Yes / No

If yes, explain below and list other family illnesses:

_____

_____

Smoke? Yes / No Amount: _____

Drink alcohol? Yes / No Amount: _____

Are you a headache patient? If yes, please see back.

Purath

HEADACHE & NEUROLOGY