Dr Supriya Thirunarayanan MD

Comprehensive Neurology Center, PA

Past Medical History ✓ (Tick the Box)

Atrial Fibrillation	☐	Hepatitis C	☐	Parkinson's disease	☐
Aortic Stenosis	☐	Stomach ulcers	☐	Stroke	☐
Heart Disease	☐	Anemia	☐	Nerve/muscle disease	☐
Heart Failure	☐	Deep vein thrombosis	☐	Neurologic Disease	☐
High Cholesterol	☐	Leukemia	☐	Alcohol Problem	☐
High Blood Pressure	☐	Pulmonary embolism	☐	Depression	☐
Myocardial infarction	☐	Infection w/ MRSA	☐	Asthma	☐
Blood clotting disorder	☐	Infection with VRE	☐	Emphysema (COPD)	☐
Heart Murmur	☐	Dementia	☐	Obstructive sleep apnea	☐
Artificial heart valve	☐	Seizure Disorder	☐	End stage renal disease	☐
Blood vessel blockage	☐	Brain tumor	☐	Urinary insufficiency	☐
Diabetes	☐	Head injury	☐	Obesity	☐
Thyroid Disease	☐	Migraine h/a	☐	Drug abuse	☐
Cancer	☐	Tremors	☐	Sexually transmitted Disease	☐

Other MEDICAL History

Social History

Tobacco Use: **Non Smoker** ☐ **Smoker** ☐ **Former Smoker** ☐ **Quit Date** _____

How Often Do You Smoke: **Daily** ☐ **Some days, but not every day** ☐ **#Of Cigarettes some in a day** ☐

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Alcohol Use

Question 1: How often did you have a drink containing alcohol in the past year?

Never ☐ **Monthly or less** ☐ **2 to 4 times a month** ☐ **2 to 3 times per week** ☐ **4 or more times a week** ☐

Question 2: How many drinks did you have on a typical day when you were drinking in the past year?

1 or 2 **3 or 4** ☐ **5 or 6** ☐ **7 to 9** ☐ **10 or more** ☐

Question 3: How often did you have six or more drinks on one occasion in the past year?

Never ☐ **Less than monthly** ☐ **Monthly** ☐ **Weekly** ☐ **Daily or almost daily** ☐

Family History

Check if any first degree relative has any Medical Problem.

Medical Conditions	Father	Mother	Siblings	Other
High Blood Pressure				
High Cholesterol				
Heart Disease				
Diabetes				
Stroke				
Cancer				
Migraines				
Thyroid Issues				
Alcoholism				
Mental Illness				
Others/Specify				

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