

HEALTH HISTORY

PAST NEUROLOGIC HISTORY:

Y	N	Have you or do you currently have any of the following
		Stroke(s)
		Migraine headaches
		Other headaches
		Seizures or epilepsy
		Other: Please list below

Past Medical History:

Y	N	Have you or do you currently have any of the following:
		High Blood Pressure
		Diabetes
		Heart Disease
		Other:

Past Surgical History:

Please list all Surgeries below:

Medications: please list

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ALLERGIES to Medications: If none leave blank

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Habits:

		Cigarettes
		Alcoholic drinks
		Other Drugs:

Family History: Please list medical problems each have or had:

Mother:	Grandmother:
	Grandfather:
Father:	Grandmother:
	Grandfather:
Brothers/Sisters:	
Other:	

Walter Taylor, M.D.

Last Name:	First Name:	Date:
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