PETER KIM, M.D.

NEUROLOGY, NEUROPHYSIOLOGY

Health Questionnaire

Date _____

Patient's Last Name _____ (First) _____ DOB: _____

What is your reason for coming to see Dr. Kim today?

_____

Review of symptoms: Do you currently have any of the following?

❑ Abdominal Pain	❑ Difficulty swallowing	❑ Loss of consciousness	❑ Seizures
❑ Ankle/foot swelling	❑ Difficulty with speech	❑ Memory loss	❑ Sexual dysfunction
❑ Anxiety	❑ Dizziness	❑ Mood changes	❑ Shortness of breath
❑ Chest pain	❑ Fever	❑ Nausea/Vomiting	❑ Sore throat
❑ Constipation	❑ Head Trauma	❑ Numbness	❑ Urinary incontinence
❑ Depression	❑ Headache	❑ Paralysis/weakness	❑ Vision changes
❑ Diarrhea	❑ Joint pain	❑ Poor appetite	❑ Weight loss or gain
❑ Difficulty breathing	❑ Loss of Balance	❑ Rash	❑ Other _____

Medications: ***Please list all medications you are taking.*** _____

_____

_____

Allergies: Do you have any drug allergies? ❑ No ❑ Yes, Name of drug_____

If so, what kind of reaction? _____

Medical History: ***Please list all your medical conditions.*** _____

_____

_____

Family History: ***Please list any diseases in your family and the relation of that person to you.***

_____

_____

Social History: ***Do you use tobacco, alcohol, or drugs? If so, which of the following and for how long?***

Tabacco ❑ everyday smoker ❑ someday smoker ❑ former smoker, stopped on_____ ❑ Never smoked

Alcohol ❑ No ❑ Yes, what kind _____ how much _____ How often _____

Drug ❑ No ❑ Yes, what kind _____ how much _____ How often _____

Are you currently driving? ☐ Yes ☐ No ***Height:*** _____ ***Weight:*** _____

What are your routine daily or weekly activities? _____

_____

Thank you for filling out this questionnaire!