Harrington
PHYSICIAN SERVICES
Compassionate Quality Care

Rania Abou Elenein, M.D. | NEUROLOGY
100 South Street, Suite 108 | Southbridge, MA 01550
Ph: (508) 764-2515 | Fax: (508) 764-2457

MRN:

NAME:

BIRTHDATE:

CSN:

Health History: New Patient

Date of appointment: ______ / ______ / ____________ (mm/dd/yyyy)

Please fill this form out as completely as possible and bring this to your appointment.

Past Medical History (Please check any medical problems that you have had in the past)

- ☐Anxiety
- ☐Arthritis
- ☐Bipolar Disorder
- ☐Borderline Personality
- ☐Cancer
- ☐Clotting disorder
- ☐Congestive heart failure
- ☐Coronary artery disease
- ☐Dementia
- ☐Depression
- ☐Developmental delay
- ☐Diabetes mellitus type 1
- ☐Emphysema
- ☐Glaucoma
- ☐Headaches
- ☐Hearing loss
- ☐Heart murmur
- ☐HIV/AIDS
- ☐Hypertension (high blood pressure)
- ☐Kydney disease
- ☐Liver disease
- ☐Memory loss
- ☐Meningitis
- ☐Movement Disorder
- ☐Neurocutaneous disorder
- ☐Neuropathy
- ☐Schizophrenia
- ☐Seizures
- ☐Stroke
- ☐Syncope (fainting)
- ☐Thyroid disease
- ☐Ulcers
- ☐Vision problems
- ☐Other (list)____

Past Surgical History (Check any other surgeries you have had and the date of surgery if you know it)

- ☐AMV surgery
- ☐Back surgery
- ☐Brain surgery
- ☐Brain biopsy
- ☐Cardiac catheterization
- ☐Carotid endarterectomy
- ☐Craniotomy
- ☐Deep brain stimulation
- ☐Epilepsy surgery
- ☐Eye surgery
- ☐Heart surgery
- ☐Heart transplant
- ☐Intracranial aneurysm surgery
- ☐Kidney transplant
- ☐Laminectomy
- ☐Liver transplant
- ☐Lung transplant
- ☐Spinal fusion cervical
- ☐Spinal fusion lumbar
- ☐Spine surgery
- ☐Vagus nerve stimulation
- ☐Valve replacement
- ☐VP shunt placement
- ☐Other (specify)_____________

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Family History

Check below to report problems your family members have had. Please state the age when they had the problem if you know it.

☐I was adopted so I do not know my family history.

	Mother	Father	Sister	Brother	Daughter	Son	Other (list)
Alzheimer's disease							
Aneurysm							
Arthritis							
Ataxia							
Blindness							
Brain tumor							
Cerebral palsy							
Childhood cognitive impairment							
Chorea							
Dementia							
Depression							
Diabetes							
Epilepsy							
Heart Disease							
Hypertension							
Migraines							
Movement Disorder							
Multiple Sclerosis							
Muscular Dystrophy							
Neurofibromatosis							
Neuropathy							
Niemann-Pick disease							
Parkinsonism							
Seizures							
Stroke							
Tay-Sachs disease							
Wilson's disease							
Other (list)							
Alive (Yes, No or N/A=not Applicable							

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Social History

Do you ever drink alcohol? ☐Yes ☐No
If yes, please indicate the quantity per week of each:

- Glasses of wine _____
- Cans/bottles of beer _____
- Shots of liquor _____
- Drinks containing 0.5 oz of alcohol _____

Are you sexually active? ☐Yes ☐No ☐Not Currently

If yes, is/are your partner(s): ☐Male ☐Female ☐Both

Type of birth control/protection currently used:

☐Not having sex (Abstinence) ☐Condom ☐Injection ☐IUD (Intrauterine Device)

☐Oral Contraceptives (Pill) ☐Patch ☐Post-menopausal ☐None ☐Other (specify) ________________

Do you use drugs? ☐Yes ☐No
If you use drugs, how many times per week? ____________________
What type(s) of drugs do you use? ____

Check one of the following about smoking tobacco:

☐Never smoked

☐Former smoker

☐Smoke some days

☐Smoke every day

☐Exposed to second hand smoke
If you smoke or used to smoke, how many packs do/did you smoke per day? ____________________________________

How many years did you smoke/have you smoked? ___________________________________

If you quit, when did you quit? ___________________________________

Do you use "smokeless tobacco?" (Select one below)

☐Former user

☐Current user

☐Never used
If you quit, when did you quit? ________________________________

Are you ready to quit smoking and / or using smokeless tobacco? ☐Yes ☐No

____ _______ / ______ / __________(mm/dd/yyyy)
Printed name of person who completed this form Date