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STROKE

Today's Date

Last Name First MI

Date of Birth Age

GENERAL PATIENT INFORMATION

You must complete or already have on file the ***patient medical history short form*** or ***long form***.
Please make sure that all of the information on your medical history form is updated including phone numbers, addresses and insurance information.

Answer the following questions and bring the answers to your appointment.

PRESENT ILLNESS - STROKE

When did the stroke occur?

When were you last "normal"?

Do you have a history of seizures or convulsions? ☐ Yes ☐ No ☐ Unknown

Have you had a previous stroke? ☐ Yes ☐ No ☐ Unknown

If YES, when?

If YES, what side of the body was affected? ☐ Right ☐ Left

Are you on blood thinner medication? ☐ Yes ☐ No ☐ Unknown

If YES, what medication?

If YES, when was it last taken?

If YES, is the medication taken consistently as ordered? ☐ Yes ☐ No ☐ Unknown

Did you or anyone in your family have a stroke at a young age? ☐ Yes ☐ No ☐ Unknown

What tests or studies have been done in the evaluation of your stroke?

☐ MRI of the brain ☐ Carotoid Ultrasound ☐ Cerebral Angiogram

☐ ECHO Cardiogram ☐ Blood tests ☐ Hypercoag panel

☐ CT angiogram ☐ MR angiogram ☐ Other

Do you have a history of previous strokes? ☐ Yes ☐ No ☐ Unknown

If YES, when did they occur?

If YES, what were your symptoms?

Do you have atrial fibrillation or a heart arrhythmia? ☐ Yes ☐ No ☐ Unknown

MEDICATIONS

What are your current medications, include hormones, birth control pills, vitamins, etc. (Name and amount/day)?

Medication	Amount	Medication	Amount
1		6	
2		7	
3		8	
4		9	
5		10	

Are you taking oral contraceptive pills? ☐ Yes ☐ No If YES, how long?

Do you take any herbal supplements? ☐ Yes ☐ No

PAST MEDICAL HISTORY, REVIEW OF SYSTEMS

Check health issues you currently have or have had in the past:

General Health Problems

- ☐ Heart problems
- ☐ High cholesterol
- ☐ High or low blood pressure
- ☐ Diabetes
- ☐ Palpitations (abnormal or fast beating of the heart)
- ☐ Pain in back of jaw (TMJ)
- ☐ Migraine or other headaches
- ☐ Other pain, location or type:

Psychological Problems

- ☐ Treatment by a psychiatrist or counselor
- ☐ Depression or unusual amounts of stress
- ☐ Panic Attacks

Cancer

- ☐ What type:
- ☐ 15 lb or more weight loss

Systemic Diseases

☐ AIDS

Metabolic Problems

☐ Arthritis
☐ Blood diseases, anemia
☐ Liver disease
☐ Low sugar (hypoglycemia)
☐ Thyroid disorders
☐ Syphilis or venereal disease
☐ Lyme disease
☐ Tuberculosis (TB)
☐ Kidney problems
☐ Dialysis
☐ Fevers or swollen glands
☐ Skin diseases
☐ Lupus
☐ Mononucleosis (Epstein Barr)
☐ Meningitis

Eye Problems

☐ Crossed eyes, lazy eye
☐ Poor vision in one eye (amblyopia)

Neurological Problems

☐ Bladder problems
☐ Problems with sexual function
☐ Loss of consciousness (faints or seizures)
☐ Pins and needles, numbness (where)
☐ Muscle weakness (where)
☐ Tremor or incoordination
☐ Trouble speaking

Surgeries

☐ Appendix ☐ Breast ☐ Cataract ☐ Carotid
☐ C-Section ☐ Ear ☐ Gall Bladder ☐ Hysterectomy
☐ Prostate ☐ Sinus ☐ Stomach ☐ Tonsils
☐ Other:

LIFE STYLE - HABITS

How many alcoholic drinks per week ? ☐ None ☐
Do you smoke cigarettes, cigars or pipes ? ☐ No ☐ Yes
How many caffeinated drinks per day? ☐ None ☐ More than 4

Do you have regular sleep/wake patterns ? ☐ No ☐ Yes

Do you salt your food? ☐ No ☐ Moderate ☐ Lots

Are you currently involved in litigation with respect to any medical problems ? ☐ No ☐ Yes

Are you usually highly stressed? ☐ No ☐ Yes

Do you usually eat 3 meals/day? ☐ No ☐ Yes

INJURIES (Check and date)

☐ Head date

☐ Neck (for example whiplash) date

☐ Dental work preceding onset of headache date

EXPOSURES OR INFECTIONS: (Check and date)

☐ Carbon Monoxide (car or house) date

☐ Tuberculosis or Cysticercosis date

☐ History of meningitis date

FAMILY HISTORY

Are there any **family members** with:

☐ Stroke

☐ Diabetes

☐ Heart disease or high blood pressure

☐ Migraine headaches

☐ Other diseases that run in the family (list)

GENERAL MEDICAL TESTS

☐ Recent general medical checkup? Date

☐ Recent blood tests (Glucose, blood count) Date

☐ Heart test (EKG, Stress test, Holter Monitor) Date

SLEEP PROBLEMS – THE EPWORTH SLEEPINESS SCALE

How likely are you to *doze off or fall asleep,* in contrast to just feeling tired, in the following situations? This refers to your usual way of life in recent times. Even if you have not done a particular activity recently, try to work out how they would have affected you. Check your chance of dozing or falling asleep as: would never doze, slight chance of dozing, moderate chance of dozing, high chance of dozing or falling asleep.

Sitting and reading	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
Watching television	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
Sitting inactive in a public place (e.g. theater)	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
As a passenger in a car for an hour	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
Lying down to rest in the afternoon	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
Sitting and talking to someone	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
Sitting quietly after lunch without alcohol	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
In a car, stopped in traffic	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High

Total points this section: _____

Answer the following as: Never, Sometimes, Often, Always

Do you fall asleep or get sleepy when driving?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you fall asleep or get sleepy when at work?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you take intentional naps?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you experience short periods of muscle weakness or loss of muscle control (especially with laughter or excitement)?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you experience vivid dreamlike episodes when falling asleep?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you feel unable to move (paralyzed) when falling asleep?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you ever experience an uncomfortable or restless sensation in your legs when you relax or are first going to sleep, that is relieved by moving or getting out of bed and walking?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always

Total points this section: _____

Combined total points both sections: _____