NeuroHope of Indiana, Inc.
6002 Sunnyside Rd.
Indianapolis, IN 46236
www.neurohopewellness.org

Medical History Intake Form

Family Physician or Primary Health Care Provider: _____

Office Phone: _____

Do you have or have you had any of the following (Please check all that apply):

AIDS/HIV Positive	☐	Heart Trouble	☐
Alzheimer's Disease	☐	Hemophilia	☐
Anaphylaxis	☐	Hepatitis A	☐
Anemia	☐	Hepatitis B or C	☐
Angina	☐	Herpes	☐
Arthritis/Gout	☐	High Blood Pressure	☐
Artificial Heart Valve	☐	High Cholesterol	☐
Artificial Joint	☐	Hives or Rashes	☐
Asthma	☐	Hypoglycemia	☐
Blood Disease	☐	Irregular Heartbeat	☐
Blood Transfusion	☐	Kidney Problem	☐
Breathing Problems	☐	Leukemia	☐
Bruise Easily	☐	Liver Disease	☐
Cancer	☐	Low Blood Pressure	☐
Chemotherapy	☐	Lung Disease	☐
Chest Pains	☐	Mitral Valve Prolapse	☐
Cold Sores/Fever Blisters	☐	Osteoporosis	☐
Congenital Heart Disorder	☐	Parathyroid Disease	☐
Convulsions	☐	Psychiatric Care	☐
Cortisone Medicine	☐	Radiation Treatments	☐
Diabetes	☐	Recent weight loss/gain	☐
Drug Addiction	☐	Renal Dialysis	☐
Easily Winded	☐	Rheumatic Fever	☐
Emphysema	☐	Rheumatoid Arthritis	☐
Epilepsy or Seizures	☐	Scarlet Fever	☐
Excessive Bleeding	☐	Shingles	☐
Excessive Thirst	☐	Sickle Cell Disease	☐
Fainting/Dizziness	☐	Sinus Issues	☐
Frequent Cough	☐	Spinal Bifida	☐
Frequent Diarrhea	☐	Stomach/Intestinal Disease	☐
Frequent Headaches	☐	Stroke	☐
Genital Herpes	☐	Swelling of Limbs	☐
Glaucoma	☐	Thyroid Disease	☐
Hay Fever	☐	Tonsillitis	☐
Heart Attack/Failure	☐	Tuberculosis	☐
Heart Murmur	☐	Ulcers	☐
Heart Pacemaker	☐	Venereal Disease	☐

If you answered yes to any of the previous conditions, please explain further: _____

_____

_____

SURGERIES: Please list any major surgery and date: _____

_____

HOSPITALIZATIONS: Please list any major hospitalizations, date and reason for stay: _____

_____

MEDICATIONS: List any prescription medications and supplements you are currently taking: _____

_____

ALLERGIES: List any drug or medical materials (latex) allergies and reaction: _____

_____

FAMILY MEDICAL HISTORY: Please list any major medical issues that have occurred in your family: _____

_____

SOCIAL HISTORY:

Do you use tobacco? □ yes □ no If yes, how many packs or cigarettes per day _____

Do you drink alcohol □ yes □ no If yes, how many drinks per week _____

To the best of my knowledge, the questions above on the form have been accurately answered. I understand that providing incorrect information can be dangerous to the treating staff, other patients and my health. It is my responsibility to update NeuroHope of Indiana of any changes in medical status.

_____

Subject Name (Printed) Date

_____

Subject Signature Date

_____

Caregiver/Power of Attorney(Printed) Date

_____

Caregiver/Power of Attorney Signature Date