Gobinder Chopra, MD & Associates
BOARD CERTIFIED IN NEUROLOGY

PERSONAL MEDICAL HISTORY FORM

Date: _____
Name: _____ Ht: _____ Wt: _____
Occupation: _____ Previous Occupation: _____
Date of birth: _____ Sex: Male Female (Circle One)
Are you: Right handed Left handed both (Circle one)
Reason for your visit today and how long you have had this problem:
_____
Is your visit related to a MVA or Work related Accident Yes No (Circle one)
If yes are you currently off work? Yes No Date last worked if answered Yes_____
Do you have any NEW medical problems or symptoms? Yes No
If yes please explain_____
Did you have any Radiology testing ordered by another Physician since scheduling this appointment? Yes No If yes where and when? _____
Have you had any recent blood tests ordered by another Physician? (In last 6 months)Yes No
If yes where and when? _____
Have you been Hospitalized since you scheduled this visit? Yes No If yes where and when?
_____
Have you seen another Neurologist other than Dr. Chopra? Yes No If yes where and when_____
Operations (Surgery) _____ Date (s) _____
_____ _____
_____ _____
List medications which you take regularly:
Type_____ Dose_____
Type_____ Dose_____
Type_____ Dose_____
Type_____ Dose_____
Type_____ Dose_____
Type_____ Dose_____
Type_____ Dose_____
Type_____ Dose_____
Diseases that run in your family:
Mother_____
Father_____
Other_____
List medication you are allergic to: Type of reaction you have
_____
_____
List all Physicians that <u>currently</u> treat you for other conditions:
_____
_____
How did you hear about us?_____