University of California
San Francisco

Department of Neurology
Surgical Movement Disorders

Why are you here today?		
Social History:	Do you smoke? Yes☐ No ☐ Do you drink alcohol? Yes☐ No ☐ Have you ever used recreational drugs? Yes☐ No ☐ If yes, provide details:	Pharmacy Information:
Do you have allergies?	If yes, provide details:	

Medication	Dose	Frequency	Time
Example: Sinemet	***25/100***	***3 times a day***	***1 at 6:00 AM, 1at 12:00 PM, 1 at 6:00 PM total 3 pills per day.***

***REMEMBER TO UPDATE YOUR MEDICATIONS.**

MEDICAL HISTORY
Have you had any operations or hospitalizations in the past? Yes ☐ No ☐ If yes, specify Reason for Hospitalization: (Specify Date /Year)

_____

DO YOU HAVE A HISTORY OF THE FOLLOWING ILLNESSES? CHECK CORRECT RESPONSE

	Yes	No	Not Sure		Yes	No	Not Sure
Arthritis	☐	☐	☐	Loss of Consciousness/Amnesia	☐	☐	☐
Cancer	☐	☐	☐	Meningitis or Encephalitis	☐	☐	☐
Chronic Lung disease	☐	☐	☐	Psychiatric/Psychological Treatment	☐	☐	☐
Depression	☐	☐	☐	Rheumatic fever	☐	☐	☐
Diabetes	☐	☐	☐	Seizure	☐	☐	☐
Epilepsy	☐	☐	☐	Serious Head Injury	☐	☐	☐
Gallstones	☐	☐	☐	Stomach Ulcers	☐	☐	☐
Headache	☐	☐	☐	Stroke	☐	☐	☐
Heart Disease / Attack / Murmur	☐	☐	☐	Syphilis	☐	☐	☐
Hypertension / High blood pressure	☐	☐	☐	Thyroid disease	☐	☐	☐
Liver disease / Hepatitis	☐	☐	☐	Tuberculosis	☐	☐	☐
Kidney disease / Renal Stones	☐	☐	☐	History of Other Medical Problems	☐	☐	☐

If you have answered yes to any of these, please provide details and date of occurrence: _____

Have you ever had a blood transfusion or received either clotting factor concentrates or platelet transfusions? Yes ☐ No ☐ (If yes, specify the date/year) _____

Are you Left or Right handed? Right ☐ Left ☐ (please check)

List your post Surgeries: (Specify Date /Year & Type of Surgery)

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