Name: _____ Age: _____ Are you RIGHT or LEFT handed? (circle)

Referring Physician's name, address and phone number: _____

_____

You are here to see Dr. Reif, or Dr. Oh for: Neurology Sleep disorder (please circle)

Briefly describe the main medical concern you want the doctor to address:

_____

_____

Past Medical History: Check all that apply in either column for **YOU** or **FAMILY**

	YOU	**FAMILY**		**YOU**	**FAMILY**
Alzheimer's Disease	____	____	Hypertension	____	____
Angina	____	____	Insomnia	____	____
Arthritis	____	____	Irregular heart beat	____	____
Asthma	____	____	Kidney problems	____	____
Blood Clots	____	____	Liver conditions	____	____
Cancer	____	____	Multiple Sclerosis	____	____
Colitis/Chron's	____	____	Pancreatitis	____	____
Diabetes	____	____	Parkinson's disease	____	____
Diverticulitis	____	____	Osteoporosis	____	____
Emphasymea	____	____	Sleep apnea	____	____
Gall stones	____	____	Stroke	____	____
GI Ulcer	____	____	Substance abuse	____	____
Glaucoma	____	____	Seizures	____	____
Head trauma/injury	____	____	Tuberculosis	____	____
Heart disease	____	____	Thyroid disease	____	____
High cholesterol	____	____	Other: _____	____	____

Have you ever had surgery? YES ____ NO ____ If yes what type and when?

_____

_____

Do you: drink alcohol? Yes ___ NO ___ smoke: Yes ___ NO ___ use illicit drugs Yes ___ No ___

Occupation: _____ When was your last day of work? _____

Do you have any Medication allergies? YES ____ NO ____ If yes please list below._____

Please list all medication you take. Please include over the counter medications:

_____

_____