Medical History Form

Dr. Saurabh Kamat
Neurologist & Epilepsy Specialist

Please complete the following medical history form to help us understand your health background. This information will assist us in providing the best possible care.

Personal Information:

- **Full Name:** _____
- **Age:** _____
- **Gender:** ☐ Male ☐ Female ☐ Other
- **Contact Number:** _____
- **Email Address:** _____
- **Emergency Contact (Name & Phone):** _____

Health Information:

1. **Have you ever been diagnosed with any neurological conditions?**
   ☐ Yes ☐ No
   If yes, please specify: _____
2. **Do you have a history of any of the following? (Check all that apply):**
   ☐ Seizures
   ☐ Stroke
   ☐ Migraines
   ☐ Epilepsy
   ☐ Multiple sclerosis
   ☐ Parkinson's disease
   ☐ Memory loss or confusion
   ☐ Numbness or weakness in limbs
   ☐ Other (please specify): _____

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3. **Do you have a family history of neurological disorders?**
   ☐ Yes ☐ No
   If yes, please specify: _____

4. **Do you take any current medications?**
   ☐ Yes ☐ No
   If yes, please list all medications:

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5. **Have you had any surgeries or hospitalizations in the past?**
   ☐ Yes ☐ No
   If yes, please provide details: _____

Lifestyle Information:

1. **Do you consume alcohol?**
   ☐ Yes ☐ No
   If yes, how often? _____

2. **Do you smoke?**
   ☐ Yes ☐ No
   If yes, how many cigarettes per day? _____

3. **Do you engage in regular physical activity?**
   ☐ Yes ☐ No
   If yes, how often? _____

4. **Do you follow any specific diet or have dietary restrictions?**
   ☐ Yes ☐ No
   If yes, please describe: _____

Emergency Information:

- **Primary Care Physician:** _____
- **Allergies (if any):** _____

Patient Signature: _____
Date: _____

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