



excellence in brain, spine and pain care
neurosciencegroup

MEDICAL HISTORY

Please fill this out *before* your visit.

Name: _____ Appointment Date: _____

L or R Handed (circle) _____ DOB: _____ Sex: _____ Height: _____ Weight: _____

Provider being seen: _____

Reason for today's visit? _____

Who referred you? _____ Who is your primary care provider? _____

Previous Providers Related to Today's Visit	Specialty	Approximate Date Seen

Previous Tests Related to Today's Visit	Date of Test	Where Was Test Performed?
X-Ray of Spine / Head		
MRI Scan of Head / Neck / Back		
CAT Scan of Head / Neck / Back		
DEXA Scan (for Osteoporosis)		
EMG		
EEG		
Other		
Other		

CURRENT Medications	Dosage	Frequency

Do you have any allergies?

Allergy	Reaction	Allergy	Reaction

REVIEW OF SYSTEMS:**(Please check all that you have experienced in the last 6 months)****Neurological**

- Difficulty walking
- Falls
- Poor memory
- Difficulty finding words
- Change in your thinking
- Numbness or tingling of face
- Numbness or tingling of arm - left side
- Numbness or tingling of arm - right side
- Numbness or tingling of leg - left side
- Numbness or tingling of leg - right side
- Seizures
- Tremor

Psychiatric

- Anger
- Excessive worry
- Frequent sadness or unhappiness
- Panic
- Problems with concentration
- Unusually high energy or excitability

Head / Face

- Headaches
- Migraines
- Facial pain
- TMJ - left side
- TMJ - right side

Vision

- Blurred vision
- Double vision
- Farsighted
- Nearsighted
- Vision loss - left eye
- Vision loss - right eye

Ears / Nose / Throat

- Hearing loss - left side
- Hearing loss - right side
- Ringing in ears
- Dizziness
- Frequent sore throat
- Hoarseness
- Snoring
- Discharge from nose
- Repeated sinus infections

Cardiovascular

- Chest pain
- Palpitations
- Irregular heart beat
- Swelling of legs
- Swelling of feet
- Cold hands
- Cold feet

Respiratory

- Chronic cough
- Oxygen use - day
- Oxygen use - night
- Oxygen use - continuous
- Shortness of breath
- Wheezing

Gastrointestinal / Genitourinary

- Difficulty chewing
- Difficulty swallowing
- Poor appetite
- Constipation
- Diarrhea
- Nausea
- Vomiting
- Abdominal pain
- Blood in stool
- Dark or tarry stools
- Incontinence of stool
- Incontinence of urine
- Urinary frequency
- Blood in urine
- Pain during sex

Musculoskeletal

- Bone pain
- Cramps
- Joint pain
- Muscle loss
- Muscle pain
- Stiffness
- Weakness

Endocrine

- Always cold
- Always hot
- Excessive thirst
- Excessive urination

Constitutional

- Chills
- Fever
- Night sweats
- Weight gain (Unintentional)
- Weight loss (Unintentional)

Skin / Hair / Nails

- Changes in hair
- Changes in nails
- Changes in skin color
- Dry skin
- Eczema
- Itching
- Recurrent rashes

MEDICAL HISTORY: (Please check all that apply)		
<input type="checkbox"/> Headaches	<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Bowel problems
<input type="checkbox"/> Migraines	<input type="checkbox"/> Ventricular arrhythmia	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Stroke	<input type="checkbox"/> Aortic aneurysm	<input type="checkbox"/> Ulcerative colitis
<input type="checkbox"/> TIA	<input type="checkbox"/> Abnormal heart valve	<input type="checkbox"/> Crohn's disease
<input type="checkbox"/> Carotid stenosis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Bladder problems
<input type="checkbox"/> Head injury	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Loss of consciousness - date: _____	<input type="checkbox"/> COPD	<input type="checkbox"/> Gout
<input type="checkbox"/> Seizure - date: _____	<input type="checkbox"/> Asthma	<input type="checkbox"/> Thyroid disease - hypo
<input type="checkbox"/> Depression	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Thyroid disease - hyper
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Diabetes - type I	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Other mental illness - type: _____	<input type="checkbox"/> Diabetes - type II	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Easy bleeding	<input type="checkbox"/> Major trauma
<input type="checkbox"/> Brain aneurysm	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Cancer - type: _____
<input type="checkbox"/> Peripheral neuropathy	<input type="checkbox"/> Blood clots - lung	<input type="checkbox"/> Alcohol addiction
<input type="checkbox"/> Restless leg syndrome (RLS)	<input type="checkbox"/> Blood clots - leg	<input type="checkbox"/> Drug addiction
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> HIV
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prolonged prednisone use	<input type="checkbox"/> AIDS
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Other _____
<input type="checkbox"/> Angina	<input type="checkbox"/> Liver problems	<input type="checkbox"/> Other _____

SURGICAL HISTORY: (Please check and list date of surgery for all that apply)		
<input type="checkbox"/> Brain surgery	<input type="checkbox"/> Bowel surgery	<input type="checkbox"/> Implants Type: _____
<input type="checkbox"/> Neck surgery	<input type="checkbox"/> Bypass in the legs	<input type="checkbox"/> Intrathecal pump
<input type="checkbox"/> Back surgery	<input type="checkbox"/> Gallbladder surgery	<input type="checkbox"/> Pacemaker surgery
<input type="checkbox"/> Aneurysm surgery	<input type="checkbox"/> Gastric bypass surgery	<input type="checkbox"/> Stimulator
<input type="checkbox"/> Carotid surgery	<input type="checkbox"/> Gynecologic surgery	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Abdominal surgery	<input type="checkbox"/> Heart surgery	<input type="checkbox"/> Other _____
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Hysterectomy	

SOCIAL HISTORY: (Please circle or fill in the blank)					
Marital status:	Single	Married	Widowed	Divorced	Significant Other
Number of children:	_____		Ages of children:	_____	
Highest education completed:	Grade school	High school	College	Post-graduate	
Are you employed?	Yes	No	Occupation:	_____	
Do you have work restrictions?	Yes	No	Last day of work:	_____	

PERSONAL HABITS:				
Do You:	Yes / No	How Long	How Much	Date Quit
Drink alcohol				
Use caffeine				
Smoke tobacco				
Use smokeless tobacco				
Street drug: _____				
Street drug: _____				
Street drug: _____				

FAMILY HISTORY:
(Please check all that apply)

	Mother	Father	Sister	Brother	Daughter	Son	Maternal	Paternal	Grand mother	Grand father
Please circle if (A) Alive or (D) Deceased	A or D	A or D	A or D	A or D	A or D	A or D	A D	A D	A D	A D
Alcohol/Drug dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bone/Joint disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type:										
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart/Vascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type:										
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type:										
Spine disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type:										
Stomach/Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary/Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, including genetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROVIDER'S SIGNATURE: _____

DATE REVIEWED: _____