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)

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

SURGICAL HISTORY:
(Please check and list date of surgery for all that apply)

- ☐ Brain surgery
- ☐ Neck surgery
- ☐ Back surgery
- ☐ Aneurysm surgery
- ☐ Carotid surgery
- ☐ Abdominal surgery
- ☐ Appendectomy
- ☐ Bowel surgery
- ☐ Bypass in the legs
- ☐ Gallbladder surgery
- ☐ Gastric bypass surgery
- ☐ Gynecologic surgery
- ☐ Heart surgery
- ☐ Hysterectomy
- ☐ Implants
  Type: _____
- ☐ Intrathecal pump
- ☐ Pacemaker surgery
- ☐ Stimulator
- ☐ Tonsillectomy
- ☐ Other _____

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	Grand mother: Maternal	Grand mother: Paternal	Grand father: Maternal	Grand father: Paternal
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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bone/Joint disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer Type:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetic	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart/Vascular	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung disorder Type:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Multiple sclerosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Muscular dystrophy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep disorder Type:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Spine disease Type:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stomach/Bowel	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tremor	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Urinary/Kidney	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other, including genetic	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Type:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Type:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Type:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PROVIDER'S SIGNATURE: _____ **DATE REVIEWED:** _____