NEUROLOGIC ASSOCIATES
SPINE, NERVE & BRAIN CENTER
The trusted authorities for exceptional care

HEALTH HISTORY

Complete prior to first appointment

Patient Name: _____ **Birth Date**:_____

Occupation: _____

Chief Complaint:_____

History of present illness:

LOCATION: (Where is the pain/problem?)	**QUALITY:** (Example: ache, stab, burn)
SEVERITY: (How severe is the pain from 0-10?)	**DURATION:** (When did the symptoms start?)
TIMING: (Does the pain/problem occur at a specific time?)	**CONTEXT:** (What event started the symptoms, or gradual?)
ASSOCIATED SYMPTOMS: _____	**MODIFYING FACTORS:** (What makes it better or worse?)

Past Medical History:

Have you ever had the following? (Please check all that apply)

❒ Measles ❒ Mumps ❒ Chickenpox ❒ Whooping Cough ❒ Polio ❒ Scarlet Fever ❒ Diphtheria ❒ Rheumatic Fever ❒ Heart Attack ❒ Irregular Heartbeat ❒ Coronary Heart Disease ❒ Heart Valve Disease	❒ High Blood Pressure ❒ Low Blood Pressure ❒ Vascular Disease ❒ Blood Clotting Disorder Type:_____ ❒ Transfusion ❒ Anemia ❒ Hemorrhoids ❒ Glaucoma ❒ Cataracts ❒ Cancer Type:_____	❒ Hernia ❒ Ulcer ❒ Hepatitis ❒ Epilepsy ❒ Stroke ❒ Migraine Headaches ❒ Arthritis ❒ Bladder Infection ❒ Venereal Disease ❒ Kidney Failure ❒ Kidney Stones ❒ AIDS or HIV	❒ Hives or Eczema ❒ Bronchitis ❒ Asthma ❒ Tuberculosis ❒ Infectious Mono ❒ Pneumonia ❒ Back Trouble ❒ Osteoporosis ❒ Thyroid Disease ❒ Diabetes ❒ Other:

Previous Hospitalizations/Surgeries/ Serious Illnesses:	When?	Where? (Hospital, City, State.)	Doctor

Social History:

Marital Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed

Number of Children: _____

Use of alcohol: ❒ Never ❒ Rarely ❒ Moderate ❒ Daily ❒ Drinks per week _____

Use of tobacco: ❒ Never ❒ Previously, but Quit_____ ❒ Current packs/day: _____

Use of drugs: ❒ Never ❒ Type/Frequency: _____

Caffeine: ❒ Never ❒ Rarely ❒ Moderate ❒ Daily

Exercise: ❒ Never ❒ Rarely ❒ Moderate ❒ Daily ❒ Activity Type: _____

Handed: ❒ Left ❒ Right ❒ Ambidextrous

Nutrition: ❒ Heart Healthy ❒ Low Sodium ❒ Carb Controlled ❒ Low Cholesterol ❒ Regular

Excessive exposure at home or work: ❒ Fumes ❒ Dust ❒ Solvents ❒ Air-borne particles ❒ Noise

Patient Name: _____ **Birth Date**:_____

ALLERGIES:	**REACTION:**

Please list *all* of your current medications,
including any over-the-counter medications, vitamins and supplements.

Medication	Dosage	Directions	Prescribing Doctor
Example: Metoprolol	50 Mg.	1 daily	Dr. W. Williams

Pharmacy of Choice:_____

Patient Name: _____ **Birth Date**:_____

Family Medical History: Please check what applies and indicate which family member.

	Family Member		Family Member
❒ Hypertension		❒ Diabetes	
❒ Coronary Heart Disease		❒ Emphysema	
❒ Hyperlipidemia		❒ Thyroid Disease	
❒ Stroke		❒ Alcoholism	
❒ Migraines		❒ Depression	
❒ Parkinson's Disease		❒ Other Mental Illness	
❒ Cancer (Type?)		❒ Multiple Sclerosis	
❒ Other		❒ Other	

Review of Systems: Please check any *current* personal symptoms below.

Constitutional Symptoms
❒ Good general health lately
❒ Recent weight gain
❒ Recent weight loss
❒ Fatigue
❒ Fever

Eyes
❒ Blurred vision
❒ Double vision
❒ Wear glasses/contact lenses

Ears/Nose/Mouth/Throat
❒ Hearing loss
❒ Ringing in ears
❒ Chronic sinus problem
❒ Nose bleeds
❒ Sore throat
❒ Difficulty swallowing

Cardiovascular
❒ Swelling feet, ankles or hands
❒ Chest pain or angina pectoris
❒ Palpitations
❒ Cold extremities

Respiratory
❒ Wheezing
❒ Chronic or frequent coughs
❒ Coughing up blood
❒ Shortness of breath
❒ Sleep apnea

Gastrointestinal
❒ Abdominal pain
❒ Loss of appetite
❒ Nausea
❒ Diarrhea
❒ Constipation

Integumentary
❒ Breast discharge
❒ Change in skin color
❒ Change in hair or nails
❒ Varicose veins
❒ Rash or itching

Neurologic
❒ Frequent headaches
❒ History of head injury
❒ Seizures
❒ Numbness or tingling
❒ Tremors
❒ Paralysis
❒ Lightheaded
❒ Dizziness

Psychiatric
❒ Insomnia
❒ Memory loss
❒ Anxiety
❒ Depression

Endocrine
❒ Change in hat or glove size
❒ Excessive thirst or urination
❒ Temperature intolerance
❒ Hormone issues

Musculoskeletal
❒ Joint pain
❒ Joint stiffness
❒ Swollen joints
❒ Difficulty walking
❒ Muscle pain or cramps
❒ Back pain
❒ Weakness

Hematologic/Lymphatic
❒ Slow to heal after cuts
❒ Bleeding/bruising tendency
❒ Enlarged lymph glands

Genitourinary
❒ Frequent urination
❒ Burning or painful urination
❒ Blood in urine
❒ Straining to urinate
❒ Incontinence or dribbling
❒ History of kidney stones
❒ Sexual difficulty

❒OTHER:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Signature of Patient or Guardian_____ Date_____