Center For Neurology Care, LLC

Patient Health History

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. **Please fill out each item.** It is important for the doctor to know that you have carefully reviewed each area on this form. This information will be entered into our computer.

Patient Last Name: ____________________ First Name: _____________ Middle Initial: ______

Date of Birth: ____________ Social Security Number: _____ - ____ - ____

Male ____ Female ____ Race _____ Pharmacy (include location): _______________________

Primary Care Physician (Required) ________________________

Referring Physician if different from Primary Care Physician: _________________________________

*Please list Physicians who are treating you and the reason:

Dr. Full Name	Condition being treated

*Are you taking any medication now? (includes prescription, over-the-counter or herbal medications)
Yes __ No __ If yes, please list below (include dosage)(If more space is needed please use blank sheet)

Medication Name	Dosage	How often?	Prescribing Physician

*Are you allergic to any medications? No ___ Yes ___ If yes please list below

Medication	Type of Reaction

*Please list any other allergies you may have:

*Are you allergic to things that touch your skin, such as latex, tape, metal? Yes ___ No ___
If yes please check appropriately: ___ latex ___ tape ___ metal

*Have you or anyone in your family ever been Diagnosed with any major health problems? Including but not limited to:

CHILDHOOD DISEASES:

Measles	Yes ___	Year? ____	Reflux	Yes ___	Year? _____
German Measles	Yes ___	Year? ____	Hepatitis	Yes ___	Year? _____
Mumps	Yes ___	Year? ____	Hernia	Yes ___	Year? _____
Scarlet Fever	Yes ___	Year? ____	Pancreatitis	Yes ___	Year? _____
Diverticulitis	Yes ___	Year? ____	Stomach ulcer	Yes ___	Year? _____
Cancer	Yes ___	Type: ________________________			Year? _____

KIDNEY AND GENDER PROBLEMS:
Renal failure Yes ___ Year?____ Prostate enlargement Yes ___ Year?_____
*Are you pregnant? Yes ___ No ___

EYES:
Cataracts Yes ___ Year? ____ Glaucoma Yes ___ Year? _____
Retinal Detachment Yes ___ Year? ____

EARS:
Hearing loss from aging,Yes ___ Year?____ Hearing loss from trauma Yes ___ Year? _____
Hearing loss unknown cause Yes ____ Year? _____

SKIN & BREAST:
Psoriasis Yes ___ Year?____ Shingles Yes ___ Year? _____

BRAIN & NERVOUS SYSTEM:
Epilepsy Yes ___ Year?____ Stroke Yes ___ Year? _____

HEART & BLOOD VESSELS:
Angina Yes ___ Year?____ Cerebro Vascular Accident Yes ___ Year? _____
Heart Attach Yes ___ Year?____ Heart Disease Yes ___ Year? _____
High Blood Pressure Yes ___ Year?____ Pericarditis Yes ___ Year? _____
Blood clots in Arms or Legs Yes _____ Year? _____

GLANDS, HORMONES & SUGAR CONTROL
Diabetes (type_____) Yes ___ Year? ____ Goiter Yes ___ Year? _____
Thyroid deficiency Yes ___ Year? ____ Thyroid excess Yes ___ Year? _____

BLOOD & LYMPH NODE PROBLEMS:
Anemia Yes ___ Year? ____

LUNGS & RESPIRATORY:
Tuberculosis Yes ___ Year? Asthma Yes ___ Year? ____ Chronic Bronchitis Yes ___ Yr.____

STOMACH & DIGESTIVE:
Cirrhosis or enlarged liver Yes ___ Year? _____

ALLERGIES, IMMUNE & INFECTIOUS PROBLEMS:
HIV Yes Year? _____

OTHER (Please Specify): ____

SURGERIES AND HOSPITALIZATIONS:
Have you been hospitalized (not for surgery) No ____ Yes ___
If yes, list hospitalizations, the reason and the date: ____
Have you had any surgeries No ____ Yes ___
If yes, list any surgeries and dates: ____
____

Patient Last Name: ____________________ First Name: _____________ Middle Initial: ______

Date of Birth: ____________ Social Security Number: _____ - ____ - ____

BACK PAIN

___ Upper Back, what part of the upper back? ____

Above the level of the shoulder blades? __ Midline __ Right __ Left

At the level of the shoulder blades? __ Midline __ Right __ Left

Below the level of the shoulder blades? __ Midline __ Right __ Left

Does the upper back pain radiate to the chest wall? __ Yes __ No

___ Lower back, what part of the lower back? ____

What is the quality (description) of the pain?

__ Aching __ Electric Shock type __ Sharp __ Other, Describe: ____________________

__ Burning __ Gnawing __ Stabbing

On a severity of scale of 1-10 (1 being little pain at all and 10 being intolerable) my pain is a: ______________

Measure the severity of the pain regarding how it affects your daily activities:

__ Mild – I am aware of it when present but it doesn't interfere with daily activities

__ Moderate – when present it interferes only with some daily activities

__ Severe – when present it interferes with most, but not all, daily activities

__ Very severe – when present I am unable to carry out any daily activities

Other description of severity: ____

Are you experiencing the pain now? __ Yes __ No

How long have you had the pain? ____

Are you experiencing hip or leg pain? __ Yes __ No

__ Left leg __ Right leg __ Both legs

Where is the hip or leg pain located?

__ Hip __ Groin area __ Thigh __ Knee __ Lower leg

__ Ankle __ Feet __ Toes

What is the quality (description) of the pain?

__ Aching __ Burning __ Cold sensation __ Hot sensation __ Stabbing __ Weakness

__ Gnawing __ Numbing __ Heavy sensation __ Electric shock __ Tingling __ Pins/Needles

Where did problem first occur?

__ Around the house __ Recreation __ School __ Fall __ Unknown

__ Injury on the job?

Date of accident: __________________________

Description of accident or injury: ____

Was it reported to workman's comp? __ Yes __ No

Are you out of work due to the accident or injury? __ Yes __ No

__ Motor vehicle accident?

Date of accident: __________________________

Circumstances of accident: ____

Is there litigation pending due to accident? __ Yes __ No

List any factors that aggravate the pain: ____

List any non-medical factors that relieve the pain: ____

Do you have sleep disturbance? __ Yes __ No
List any previous tests you have had for this problem: ____
List any previous treatments you have had: (home remedies, physical or occupational therapies, acupressure or acupuncture therapies, massage therapy, etc) and their effectiveness: ______________________________
____
____
List any medications you have tried for this problem and their effectiveness: ____________________________
____

Serious Injuries:
Have you ever had a serious injury such as head, neck, back or other injury? __ Yes __ No
If yes, list and describe the type of injury and when it occurred: _______________________________________
____

Family History:
Heart Disease: __ Mother __ Father __ Brother __ Sister
High Blood Pressure: __ Mother __ Father __ Brother __ Sister
Brain & Nervous:
__ Dementia __ Neurotube disease __ Stroke __ Mother __ Father __ Brother __ Sister
Lungs & Respiratory: __ Mother __ Father __ Brother __ Sister __ Lung cancer __ Asthma
Blood & lymph node: __ Mother __ Father __ Brother __ Sister Bleeding/Clotting problem
Bones, Joints, Muscles: Arthritis __ Mother __ Father __ Brother __ Sister
Osteoporosis __ Mother __ Father __ Brother __ Sister

Social History:
Place of employment: (if any) ____
Occupation: ____________________________ __ Check here if you are retired Marital status ________

Have you ever used tobacco in any form? __ Yes __ No If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____________		
Other: (list type) _________________		

Are you exposed to second hand smoke? __ Yes __ No

Have you ever used alcohol in any form? __ Yes __ No If yes, please complete the following:

Type of Alcohol	From year	To year
Beers per wk: ______ Wine (glasses) per wk: ________________		
Other: (list type)		

Hand dominance: __ Right __ Left
Living setting: __ Alone __ Spouse __ Children __ Mother __ Father __ Nursing Home
__ Assisted living __ Other: ____

General Health: List any problems you have or have had in the following areas:
(Fatigue, Fever, Unintentional weight loss, Unintentional weight gain, or other problems) _______________________
____

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Eye and Ear (loss of vision, hearing loss, ringing in the ears, or other problems): __ Yes __ No
If yes, please list: ____

Mental and Emotional health problems (nervousness, depression or other problems): __ Yes __ No
If yes, please list: ____

Brain or Nervous system problems (difficulty remembering, loss of consciousness, seizures or other problems)
__ Yes __ No If yes, please list: ____

Bones, Joints and Muscle problems (painful joints, loss of muscle strength, swelling of joints, numbness/tingling):
__ Yes __ No If yes, please list: ____

This information is very important for us to have for your treatment. Thank you very much for filling out these forms as completely as possible.