Personal Health History

Today's Date: ___________________

CENTER FOR NEURO AND SPINE

Name: ____ Date of Birth: __________________

Email Address: ____

Gender: _____________ Age: ______________ Height: _______________ Weight: _____________________

Primary Care Physician: _______________________ Referring Physician: ______________________________

Pharmacy Name/Location: ____________________________ Phone: _______________________

Do you have any advanced directives? (Circle any that apply):

Living Will **Healthcare Power of Attorney** **DNR**

What Brings you to our office?

____

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____

Medicine Allergies (Please list Reaction):

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Current Medications:

Name of Medication	Dose	Frequency	Prescribed By

Medical History (Check all that apply)

Anemia		Diabetes	
Anesthesia Reaction		High Cholesterol	
Angina (chest pain)		Fibromyalgia	
Heart Arrhythmia		Headaches / Migraines	
Arthritis		Hepatitis / Liver Disease	
Asthma		High Blood Pressure	
Atrial Fibrillation		Intracranial Tumor	
Blood Clots		Multiple Sclerosis	
Cancer (type)		Parkinson Disease	
Cerebral Atherosclerosis		Renal Disease	
Cerebral Infarction		Seizure Disorder	
Congestive Heart Failure		Spinal Cord Tumor	
COPD		Stroke	
Coronary Artery Disease		Thyroid Disease	
Rheumatoid Arthritis		Other:	

If you are a female and over the age of 65: Have you had a Bone Density Scan done? YES / NO N/A

Surgical History:

Type of Surgery	Year of Operation	Physician

Family History:

Alzheimer's Disease		Dementia		Parkinson's Disease	
Arthritis		Diabetes		Renal Failure	
Asthma		Elevated Lipids		Seizure Disorders	
Cancer (type)		Heart Attack		Stroke / TIA	
Cardiovascular Disease		High Blood Pressure		Thyroid Disorder	
Congestive Heart Failure		Kidney Failure		Other:	
Coronary Artery Disease		Osteoporosis			

Social History

Occupation: _________________________________ Place of Employment: __________________________

Do you use tobacco: YES / NO What kind?______________________ How Much:___________________

Have you ever tried to quit? YES / NO N/A

Do you drink alcohol? YES / NO What kind?______________________ How Often:___________________

Do you drink caffeinated beverages? YES / NO What kind?_________________ How Often?___________

Have you had any falls in the past year? YES / NO If so, how many?_________________

Do you have any difficulties with activities of daily living? (i.e. walking, bathing, dressing, cooking) YES / NO

History of Present Illness

Duration of present complaint: ____

Is this associated with: (circle any that apply**) an accident an injury at work a legal situation**

Have you had any recent imaging (i.e. CT scan, Xray, MRI) ____

Date of imaging: ____

Have you been treated with: (circle any that apply**) Physical Therapy Chiropractic Treatment**

Pain Management Injection Home Exercise Program Pain Medications (Please list**)**

Start Date: ____________________ End Date: __________________________

How would you rate your pain on a scale of 0-10

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worse Pain)

Please indicate where you are having pain / numbness / tingling: