



NEUROLOGY AND SPINE CENTER

PATIENT HISTORY FORM

Patient Name _____

Today's Date: _____

Primary Care Physician: _____ Referring Physician: _____

Race: () American Indian/Alaska () Native Hawaiian () Black African American () Asian () White () Other

Ethnicity: () Hispanic/Latino () Non Hispanic/Latino

Highest Level of Education: _____ Hobbies: _____

Medications: (list all current and recent medications.)

If you have a list we will copy it for you:

Medication Allergies:

Past Surgery:

Social History:

History of smoking: Past/Quit Date: _____

Current/Type: _____ Amount: _____ packs per day.

Illegal Drug Use?: Current () No () Yes _____

Alcohol Use?: () No () Yes, _____ drinks per day.

Marital Status: _____ Number of children: _____

List any current family illness or cause of death: (include age of death)

Mother: _____

Father: _____

Siblings: _____ Other: _____

Check any items below that may apply to your Medical History:

General		Brain	Lung/Cardio/Vascular	GI/Liver	Musculo/Skeletal
() AIDS/HIV	() Eye Problems	() Dementia	() Asthma	() Gall Stones	() Rheumatoid
() Alcoholism	() Glaucoma	() Headaches	() Bronchitis	() Colitis	() Osteoarthritis
() Anemia	() Hearing Loss	() Migraines	() COPD/Emphysema	() Gall Bladder	() Osteoporosis
() Anxiety	() Mumps/Measles	() Mental Illness	() CHF	() Hemorrhoids	() Fractures
() Blood Transfusion	() Rubella	() Seizures	() Heart Attack	() Hepatitis	() Tendonitis
() Cancer	() Thyroid	() Stroke	() High Blood Pressure	() Liver Disease	() Back Pain
() Chicken Pox	() Other: _____	() TIA	() Phlebitis/Clots	() Ulcer	() Neck Pain
() Shingles	_____	() Other: _____	() Pneumonia	() Other: _____	() Hip Pain
() Depression	_____	_____	() Pulmonary Embolus	_____	() Joint Pain
() Diabetes	_____	_____	() Sleep Apnea	_____	() Other: _____
	_____	_____	() Other: _____	_____	_____

Patient / Responsible Party Signature: _____ Date: _____

Patient's Name (Printed): _____