NEUROLOGY AND SPINE CENTER

PATIENT HISTORY FORM

Patient Name_____ **Primary Care 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

Alcohol Frequency:_____ Amount:_____

Marital Status: _____ Number of children: _____

Family Medical History:

Mother:_____

Father:_____

Sister: _____Brother: _____

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): _____

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