

MEDICAL HISTORY

Name _____ Date _____ Age _____ R L Handed

Referring Physician _____ Primary Care Physician _____

Reason for today's appointment: _____

Medical History

Past & Present Medical Problems _____

Hospitalizations / Surgeries _____

Trauma / Accidents _____

Current Medications _____

Allergies or Intolerance to Medications or Dyes (*List medication and reaction.*)

Allergies _____

Intolerance (*i.e., nausea*) _____

Social History

Employment / Job Description _____

Hobbies _____

Recent Travel _____

Exposure to Chemicals Poison Fumes Toxins

Describe _____

Tobacco Use Never Yes Quit - When? _____

Alcohol Use Never Occasional Other _____

Family History

Major Family Illness _____

Sleep Problems

Loud Snoring Apnea (stop breathing) Restless Leg Jerks

Frequent Nightmares Inability to Sleep Sleepwalking Excessive Daytime Sleepiness

(Continued on reverse side)

Review of Systems

Eyes - Ears - Nose - Throat _____

Respiratory _____

Cardiovascular (heart, poor circulation, etc.) _____

Gastrointestinal (stomach, bowels, liver) _____

Genitourinary (urination problems or frequent infections) _____

Musculoskeletal (muscle, joints) _____

Integument (skin problems) _____

Endocrine (hormone problems) _____

Hematology - Lymphatic - Immunology (blood disorders or allergies) _____

Psychological (anxiety, depression, etc.) _____

Studies

Month/Year

Place of Service

EEG - Brain Wave _____

EMG/NCV _____

(shocks & needle pokes to arms or legs)

Evoked Potentials _____

(flashing checkerboard/clicks in ears/shocks on feet)

Lumbar Puncture _____

(spinal tap)

CT Scan _____

Head _____

(head in big doughnut)

Cervical Spine _____

Thoracic Spine _____

Lumbar Spine _____

Other _____

MRI *(body goes into a tight tube - loud clunking sound)*

Head _____

Cervical Spine _____

Thoracic Spine _____

Lumbar Spine _____

Other _____

Myelogram _____

(spinal tap with dye put in)

XRAY _____

Cervical Spine _____

Thoracic Spine _____

Lumbar Spine _____

Skull _____