

**Pacific Brain & Spine
Medical History Form**

Name: _____ **Age:** _____ **Today's Date:** _____

Who is your primary care physician? _____

Describe the problem you want the doctor to address:

Which is your dominant hand? Right Left **Your height:** _____ **Weight:** _____

Please circle any of the following problems that pertain to you:

| | | |
|---------------------|--------------------------|-----------------------------|
| Weight loss/gain | Shortness of breath | Bowel/Bladder incontinence |
| Fatigue | Asthma | Erectile dysfunction |
| Skin Changes/rashes | Emphysema/Bronchitis | Muscle Weakness/spasm |
| Headache | Heart Disease | Loss of sensation /numbness |
| Vision Changes | High Blood Pressure | Swelling of Extremity |
| Hearing Loss | Nausea/Vomiting | Diabetes |
| Dizziness | Diarrhea/Constipation | Depression/Anxiety |
| Bleeding Problems | Problems with Anesthesia | Seizures |

Does anyone else in your family have neurological or spinal problems? No Yes

Please list ALL of your current medications:

| | | | |
|------------------|-------------|------------------|-------------|
| <u>Drug Name</u> | <u>Dose</u> | <u>Drug Name</u> | <u>Dose</u> |
|------------------|-------------|------------------|-------------|

Please list any previous hospitalizations and surgeries:

| | | |
|-------------|----------------|--|
| <u>Date</u> | <u>Problem</u> | <u>Facility where treatment occurred</u> |
|-------------|----------------|--|

Please list any ALLERGIES or bad reactions to drugs:

| | |
|-----------------------|----------------|
| <u>Drug Name/Type</u> | <u>Problem</u> |
|-----------------------|----------------|

Social History

Your marital status: M D W S **Do you have children living at home:** Yes No

Occupation: _____ **If not working, last date worked?** _____

Do you smoke? No Yes

Do you drink alcohol? None Occasionally Moderately Heavily