

Medical History Form

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

What would you like to be called? _____

Who is your primary care physician? _____

Describe the problem that you want the doctor to address:

Is this the result of an accident? Yes No

Explanation:

Date of Accident: _____

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 Change/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:

Drug Name	Dose	Drug Name	Dose
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What is your preferred pharmacy?

Name: _____ **Phone #:** _____

Please list any previous hospitalizations and surgeries:

Date	Problem	Facility where treatment occurred
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Please list any ALLERGIES or bad reactions to drugs:

Drug Name/Type	Problem
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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

Is it okay to leave sensitive information on voice mail? If so, what is the number?

NEUROSURGERY

Jeffrey B. Randall, MD

Lawrence D. Dickinson, MD

Ronnie I. Mimran, MD

MAILING ADDRESS

20055 Lake Chabot Road,
Suite 110
Castro Valley, CA 94546

OFFICE LOCATIONS

Castro Valley
510-886-3138

San Ramon
925-355-9537

Oakland
510-886-3138

Fax
510-373-1616

www.pacbrain.com