Port City Neurosurgery & Spine

Patient History Form

Today's Date: _____

Name: _____ DOB: _____

Referring Doctor: _____ Primary Care Doctor: _____

Reason for Visit/Chief Complaint: _____

When did this complaint start? _____

Have you done any of the following for this complaint (please check all that apply)?

Physical Therapy (duration, date of last visit and where)		Chiropractic treatment	☐
Over-the-counter meds (please list and for how long)		Heat	☐
Injections (include doctor's name and when)		Ice	☐

	Y (include date of injury)	N
Is the problem work related?	☐	☐
Are we filing Workman's Comp?	☐	☐
Is this related to an auto accident?	☐	☐
Are you on disability? If so, why and since when?	☐	☐

MEDICAL HISTORY Please check those that apply to you.

Condition	Y	Condition	Y	Condition	Y	Condition	Y
Hypertension	☐	Obesity	☐	Stroke	☐	Chronic Fatigue	☐
High Cholesterol	☐	Asthma	☐	Seizure	☐	Chronic Pain	☐
Heart Attack	☐	Emphysema	☐	Dementia	☐	Depression	☐
Irregular Heartbeat	☐	Pulmonary Embolus	☐	Parkinson's	☐	Anxiety	☐
Heart Murmur	☐	COPD	☐	Tremor	☐	Suicide Attempt	☐
Atrial Fibrillation	☐	DVT	☐	Migraine	☐	Schizophrenia	☐
Bleeding/Clotting Disorder	☐	Glaucoma	☐	Sleep Apnea	☐	Bipolar disorder	☐
Hypothyroid	☐	Cataracts	☐	Osteoarthritis	☐	Anorexia/Bulimia	☐
Hyperthyroid	☐	Acid Reflux	☐	Osteoporosis	☐	Sexual Abuse	☐
Thyroid Goiter/Nodule	☐	Diverticulitis	☐	Rheumatoid Arthritis	☐	Cancer (type):	☐
Diabetes	☐	Kidney Disease	☐	Fibromyalgia	☐	_____	
Diabetic Neuropathy	☐	Bleeding Ulcer	☐	Post Laminectomy Syndrome	☐	_____ _____	
Other:							

Trauma History: _____

Past Surgeries and Dates: _____

SPINE/ PAIN HISTORY (please check if applicable): I have Chronic Pain in my: ☐Neck / ☐Back / ☐Both

Name of Pain Clinic: _____ Pain Contract: Yes – Start date: _____ / ☐ No

Have you ever been discharged from a pain clinic for breaking a pain contract? (please check) ☐Y / ☐N

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Review of Systems: Please check only those that currently apply to you.

CONSTITUTIONAL		**GASTROINTESTINAL**		**GENITOURINARY**	
Weight Loss	☐	Heartburn	☐	Pain Urinating	☐
Fatigue	☐	Nausea/ Vomiting	☐	Frequency	☐
Fever	☐	Constipation	☐	Nighttime Frequency	☐
Insomnia	☐	Loss of Appetite	☐	Difficulty Starting to Urinate	☐
CARDIOVASCULAR		Jaundice	☐	Difficulty Emptying Bladder	☐
Murmur	☐	Abdominal Pain	☐	History of Kidney Stones	☐
Chest Pain	☐	Black Stools	☐	Blood in Urine	☐
Palpitations	☐	Bloody Stools	☐	Erectile Dysfunction	☐
Fainting Spells	☐	**NEUROLOGICAL**		Retrograde Ejaculation	☐
Shortness of Breath	☐	Seizures	☐	**EYES**	
Difficulty Breathing when Lying Flat	☐	Weakness/ Paralysis	☐	Double Vision	☐
Swelling Ankles/ Other	☐	Numbness	☐	Blurred Vision	☐
MUSCULOSKELETAL		Tremors	☐	**HEMATOLOGIC/ LYMPH**	
Joint Pain/ Swelling	☐	Headache	☐	Prolonged Bleeding	☐
Stiffness	☐	Memory Loss	☐	Easy Bruising	☐
Muscle Pain	☐	Trouble finding words	☐	**ALLERGIC/ IMMUNOLOGIC**	
Back Pain	☐	Balance Problems	☐	Hay Fever/ Asthma	☐
Neck Pain	☐	**EAR, NOSE, THROAT**		Hives/Eczema	☐
Shoulder Pain	☐	Difficulty Hearing	☐	HIV	☐
Hip Pain	☐	Ringing in Ears	☐	Hepatitis	☐
ENDOCRINE		Dizziness	☐	MRSA/ VRE	☐
Loss of Hair	☐	Sinus Trouble	☐	**SKIN**	
Heat/ Cold Intolerances	☐	Trouble Swallowing	☐	Rash	☐
Change in Nails	☐	**RESPIRATORY**		Lesions	☐
PSYCHIATRIC		Cough	☐	**FEMALE ONLY**	
Anxiety/ Depression	☐	Coughing Blood	☐	Menopause	☐
Mood Swings	☐	Wheezing	☐	Are Periods Regular?	☐
Difficult Sleep	☐	Shortness of Breath	☐	**OTHER?** _____	

How many flights of stairs can you climb before you get short of breath? _____

SOCIAL HISTORY

Do you currently…	**Y**	**N**
Smoke / Dip / Chew tobacco?	Packs/Day _____ How long? _____	☐
Consume alcohol?	Beverages/week: _____	☐
Illegal use of drugs? (please list)		☐
Have you ever had a problem with drugs and/or alcohol? If so, which one?		☐
If you quit any of the above, please indicate which one, amount of prior usage, and when quit.		

Marital Status (please check): ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Partner

How many children do you have? ____

Education (please enter highest grade completed):

Grade School _____ High School _____ Vocational _____ College _____ Post Graduate _____

Current Occupation: _____ Former Occupation: _____

Dietary Status (please check): ☐ Meat and Vegetables ☐ Vegetarian ☐ Vegan ☐ Other: _____

☐Restrictions: _____

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MEDICATIONS (Please list any additional medications you are taking on a separate sheet of paper)

Medication Allergies/Reaction: _____

_____

Medication	Dose	Frequency	For

FAMILY HISTORY

Family Members	Living?	If Deceased, Age When Died and Cause of Death
Mother		
Father		
Sister(s)		
Brother(s)		

Family History of…	Y		Y		Y
Hypertension	☐	Diabetes	☐	Alcohol/Drug Abuse	☐
Heart Attack	☐	Obesity	☐	Suicide	☐
Stroke	☐	Rheumatoid Arthritis	☐	Cancer (indicate type)	☐
Spine Surgery	☐	Brain Surgery	☐	Brain Tumor	☐
Brain Aneurysm	☐	Osteoporosis	☐		