Iredell Neuro Spine

Past Medical History / Review of Systems

Name: _____ **Date Of Birth:** _____

Cell Phone: _____ **Occupation:** _____

Reason for today's visit: _____

When did your symptoms start? _____

If Work related, what were you doing at the time of the accident? _____

Date of injury? _____ **Date reported to employer?** _____

Was this a result of a motor vehicle accident (MVA)? _____ **Date of MVA?** _____

Have you received any treatment for this problem? _____ **If so , who did you see?** _____

Please circle if you have had: Medications Physical therapy Chiropractic Care Surgery

Dates of treatment? _____

Do you have any of the the following? Circle all that apply. If no select select none. None

General	Weight loss	Recent fever	Loss of appetite	
Skin	Frequent rash	Skin ulcers	Lumps	
HEENT	Hearing Loss	Changes in vision	Tooth pain Bleeding gums	
	Hoarsness	Frequent sore throat	Ringing in ears	
Heart/Lungs	Chest pain	Palpitations	Chronic cough	Shortness of breath
Gastrointestinal	Heartburn	Blood in Stool	Difficulty Swallowing	
	Nausea, vomiting, constipation	Loss of bowel control		
Genitourinary	Painful Urination	Blood in Urine	Difficulty urinating	Hesitancy
Musculoskeletal	Arm weakness	Neck pain	Difficulty walking	Leg weakness
	Back pain	Leg pain	Joint pain	Joint swelling
Neurological	Dizziness	Headaches	Falls	Numbness Tingling Balance problems
Psychiatric	Depression	Sleep Disorder	Anxiety	Suicidal thoughts
Endocrine	Cold Intolerance	Heat Intolerance	Excessive thirst or hunger	
Hematology	Easy bruising	Easy bleeding		

PAST MEDICAL HISTORY	**Please circle all that apply**			
High blood pressure	Stomach ulcers	COPD Sleep apnea	Diabetes	Heart attack (Year___)
High cholesterol	Acid reflux	Sickle cell disease	Thyroid problems	Stents (Year_____)
Osteoarthritis	Liver disease	Bleeding disorder	History of MRSA	Pacemaker
Rheumatoid arthritis	Kidney disease	Blood clots (Year_____)	HIV positive	Cancer (Location & Year _____)

Any other medical problems: _____

ALLERGIES (Please include your REACTION to listed allergies)

Medication allergies: _____

Other allergies: _____

FAMILY HISTORY (Please circle if your family member has any of the following. If deceased, list reason for death if known)

Mother: High blood pressure Diabetes Heart Disease Cancer COPD Asthma Deceased

Father: High blood pressure Diabetes Heart Disease Cancer COPD Asthma Deceased

Sister: High blood pressure Diabetes Heart Disease Cancer COPD Asthma Deceased

Brother: High blood pressure Diabetes Heart Disease Cancer COPD Asthma Deceased

SOCIAL HISTORY:

Are you Right or Left Handed? (Please circle one)

Do you smoke? Current every day smoker How much per day? _____
Occasional smoker Former smoker Quit date _____
How Long have you smoked? _____ Never smoker

Do you use other Tobacco products (Please list type)**? _____**

Do you use alcohol? YES NO Type & Amount: _____

Do you use recreational drugs? YES NO Which? _____

Do you consume caffeine? YES NO How Much: _____

Do you have metal in your body? YES NO WHERE? _____

Are you taking or have you ever taken blood thinners? YES NO

If Yes, which one?_____

Medications (Name, dosage, frequency) Include prescription, over the counter & vitamins/supplements:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list all your previous surgeries:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you ever had any problems with anesthesia? YES NO

If yes, please list reaction _____

Please list your pharmacy: ***Local pharmacy*** **: _____**

Mail in Pharmacy: **_____**