

GEORGIA BRAIN AND SPINE CENTER
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www.georgiabrainandspine.com

PATIENT MEDICAL HISTORY

****All of the information requested is extremely important. We need complete and concise answers to****
ALL of the questions in order to provide you with the safest and very best medical care.

PERSONAL INFORMATION

Date: _____

Patient Name _____

Last

First

Middle

Address _____

Street

City

State

Zip Code

Home Phone: (____) _____ Cell Phone: (____) _____

Date of Birth: ____/____/____ Gender: M or F Age: ____ SSN# _____

Occupation: _____ Employer _____ Work Phone # _____

Emergency Contact and Phone #: _____

Family Physician/Internist _____ Phone #(____) _____

Referring Physician _____ Phone #(____) _____

Other Referral _____ Phone # (____) _____

INSURANCE INFORMATION

Primary Insurance _____ ID# _____ Group# _____

Address _____

Insured Name _____ Relationship to Insured _____

Secondary Insurance _____ ID# _____

Address _____

Group # _____ Insured Name _____ Relationship _____

Auto/Workers Comp Insurance _____ Claim# _____

Address _____

Date of Injury/Accident _____ Type of Injury Auto Workers Compensation

Adjusters Name _____ Phone # (____) _____

MEDICAL INFORMATION

Patient Name: _____

Reason for your visit today? _____

How long have you had this problem? _____

Were you injured in an accident? Yes No If yes check one: Motor Vehicle Accident
 Worker's Comp Accident other _____

Have you had any other prior injuries? Yes No If yes, please list: _____

MEDICAL INFORMATION CON'T:

Have you had same or similar symptoms in the past? Yes No If yes, please describe:

Have you had any of the following treatment(s) for your current symptoms?

	<u>No</u>	<u>Yes</u>	<u>Length of Treatment</u>	<u>Treatment Provider</u>
Traction	___	___	_____	_____
Chiropractic Manipulation	___	___	_____	_____
Physical Therapy	___	___	_____	_____
Massage	___	___	_____	_____
Exercise Therapy	___	___	_____	_____
Trigger Point Injections	___	___	_____	_____
Acupuncture	___	___	_____	_____
Epidural Steroid Injections	___	___	_____	_____

Height _____ Weight _____ Are you Claustrophobic? Yes No

PAST MEDICAL HISTORY:

Any metal in your body? (Pacemaker, aneurysm clips, rods, screws, pins shrapnel etc.) Yes No

If yes, explain: _____

Have you ever been treated for:

	<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>
Anemia	___	___	Bleeding Disorder	___	___
High Blood Pressure	___	___	Heart Attack	___	___
Ulcer	___	___	HIV/AIDS	___	___
Cancer	___	___	Asthma and/or Emphysema	___	___
MRSA	___	___	Liver Problems	___	___
Epilepsy	___	___	Kidney Problems	___	___
Stroke	___	___	Heart Disease/Angina	___	___
Diabetes	___	___	Alcohol or Drug Abuse	___	___

Please list any other serious medical conditions not on the above list: _____

Patient Name: _____

ALLERGIES: Please list any medication or other allergies that you might have.

Latex Allergy: _____ YES _____ NO

PREVIOUS SURGERY: Please list **ALL** operations you have had.

Type of surgery	Month/Year	Surgeon	City
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT MEDICATIONS: Please take the time to completely and accurately list **ALL** of the medications you currently take, including aspirin, vitamins and other supplements. (You may attach a medication list.)

Name of medication	Dosage	How often	Taken for:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY: Please list any serious illnesses that have occurred in your family.

Cancer Yes [] No [] Relation _____

Heart Disease Yes [] No [] Relation _____

Stroke Yes [] No [] Relation _____

Diabetes Yes [] No [] Relation _____

Aneurysm Yes [] No [] Relation _____

Brain Tumor Yes [] No [] Relation _____

Other Neurological or Muscular Diseases
Yes [] No [] Relation _____

Other serious illnesses
Yes [] No [] Relation _____

SOCIAL HISTORY:

Patient Name: _____

Married? Yes [] No [] Spouse's name and phone # _____

Is there a family member or friend living with or near you who would be available to assist you once you've been discharged from the hospital, should the need arise? Yes [] No []

Name/Phone _____

Do you smoke? Yes [] No [] How many packs per day? _____

If yes, how old were you when you started? _____ How old were you when you stopped? _____

Do you drink alcohol? Yes [] No [] If yes, in an average week, how many drinks do you consume? _____

Do you use any recreational or illegal drugs? Yes [] No [] If yes, please specify: _____

Patients Name _____

D.O.B _____

REVIEW OF SYSTEMS:

Do you currently, or have you had problems with:

Constitutional

Fever..... Yes No
Weight Loss..... Yes No
Excess Fatigue..... Yes No
Night Sweats..... Yes No

Eyes

Wear Glasses..... Yes No
Date of last exam: _____
Infections..... Yes No
Injuries..... Yes No
Glaucoma..... Yes No
Cataracts..... Yes No

Ear, Nose, Throat and Mouth

Wear hearing aids..... Yes No
Date of last exam: _____
Hearing Loss..... Yes No
Ear Infections..... Yes No
Ringing in Ears..... Yes No
Left Right Both
Balance Disturbance..... Yes No
(i.e. Vertigo, spinning)
Nosebleeds..... Yes No
Nasal Congestion..... Yes No
Nasal Drainage..... Yes No
Inability to smell..... Yes No
Sinus Problems..... Yes No
Sore Throats..... Yes No
Mouth Sores..... Yes No

Cardiovascular

Chest Pain or Angina..... Yes No
Date of last EKG: _____
High Blood Pressure..... Yes No
Irregular Pulse..... Yes No
Heart Murmur..... Yes No
High Cholesterol..... Yes No
Swelling of feet/hands..... Yes No
Leg pain while walking... Yes No

Respiratory

Asthma..... Yes No
Chronic Cough..... Yes No
Emphysema..... Yes No
Shortness of breath..... Yes No
Bronchitis..... Yes No
Pneumonia..... Yes No
Lung Cancer..... Yes No
Bloody Sputum..... Yes No
Date of last chest x-ray: _____

(Circle yes or no)

Gastrointestinal

Indigestion or Pain with eating..... Yes No
Nausea..... Yes No
Blood in your vomit..... Yes No
Liver Disease..... Yes No
Jaundice..... Yes No
Abdominal Pain..... Yes No
Change in Bowel Habits..... Yes No
Ulcer or Gastritis..... Yes No

Genitourinary

Urinary Tract Infections..... Yes No
Painful urination..... Yes No
Blood in your urine..... Yes No
Incontinence..... Yes No
Kidney Stones..... Yes No
Prostate Cancer (Males)..... Yes No
Endometriosis (Females)..... Yes No
Uterine or Cervical Cancer..... Yes No

Musculoskeletal

Broken bones..... Yes No
List: _____
Neck pain..... Yes No
Arm pain Yes No
Arm weakness Yes No
Leg pain Yes No
Leg weakness..... Yes No
Back pain..... Yes No
Joint pain or swelling..... Yes No
Arm numbness/tingling..... Yes No
Leg numbness/tingling..... Yes No

Integumentary

Skin Disease..... Yes No
Skin Cancer..... Yes No
Breast pain, tenderness or swelling
(Females)..... Yes No
Nipple discharge (Females)..... Yes No
Date and result of last Mammogram:
(Females) _____

Neurological

Fainting spells or "Blacking Out"..... Yes No
Seizures..... Yes No
Memory Problems..... Yes No
Disorientation..... Yes No
Difficulty with speech..... Yes No
Headache..... Yes No
Double or blurred vision..... Yes No
Face weakness..... Yes No
Coordination in arms..... Yes No
Coordination in legs..... Yes No

Patients Name: _____

D.O.B: _____

REVIEW OF SYSTEMS CON'T:

Psychiatric

Anxiety.....Yes No
Depression.....Yes No
Other Psychiatric disorder/treatment. Yes No
If yes, please explain: _____

Endocrine

Diabetes.....Yes No
Thyroid Disease.....Yes No
Increased appetite.....Yes No
Excessive thirst or urination.....Yes No
Hormone Problems.....Yes No

Hematologic/Lymphatic

Anemia.....Yes No
Hemophilia.....Yes No
Bleeding Tendencies.....Yes No
Persistent Swollen Glands
or Lymph Nodes.....Yes No
Blood Transfusion.....Yes No
If yes, when? _____

Allergic/Immunologic

Food Allergies.....Yes No
Inhalant (nasal) Allergies.....Yes No
Immunologic Disorders.....Yes No

**The above information is accurate to the best I
have reviewed the above of my knowledge.**

Patient Signature

Date

**I have reviewed the above information with the
patient.**

Physician Signature

Date