CONFIDENTIAL MEDICAL HISTORY RECORD

NEUROSURGICAL ASSOCIATES

A practice of Lehigh Valley Physician Group

Full name: _____ **Date:** _____

Birthdate: _____ **Height:** _____ **Weight:** _____ **Male** □ **Female** □

I. Why are you here? Please describe your pain / symptoms:

_____

_____

_____

II. History of Present Illness

A. Start of Pain or Symptoms

1. Date: _____
2. Did something cause your current condition? □ Yes □ No □ Unsure
   If yes, what was the cause? _____
   _____
3. Does anything make your symptoms worse? If so, what makes them worse? _____
   _____
4. Is this work-related? □ Yes □ No Date of Injury: _____

B. Location of Pain

1. Where is the majority of your pain? _____
2. Do you have any numbness or tingling with the pain? _____
3. Does the pain move or travel? Please describe. _____
   _____
   _____

C. Previous Treatments – Please check all that apply.

□ Pain Management □ Physical Therapy □ Chiropractor
□ Muscle stimulator □ Surgery □ Medications
□ Injections □ Neck/back brace □ Other

1. When and where did you have the above? Did the treatment help or make your condition worse? Explain: _____
   _____
   _____

III. Past Medical History - Please check all that apply:

□ Diabetes □ Seizures □ High blood pressure
□ High cholesterol □ Hepatitis □ Heart disease
□ Arthritis □ Thyroid Disease □ Cancer _____
□ Migraines □ Mental Disorder □ Blood clotting problems
□ Tuberculosis □ HIV or Aids □ Kidney disease
□ Other:_____

Patient Name: _____

Medical Record Number: _____

Surgical History

Please list any surgeries you have had, listing brain or spine surgeries first.

Procedure	Date	Name of hospital or surgeon

Current Medications

Medication	Dose	How Often?	Reason for Taking

Medication / Other Allergies

Medication	Reaction

Please use additional space if necessary

Patient Name: _____

MR#: _____

IV. Family History

Condition	Who?	Condition	Who?
Heart Disease		Stroke	
Bleeding Problems		Cancer	
High Blood Pressure		Migraines	
Mental Disorder		Diabetes	
Other:			

V. Social History

A. Family Situation – please check applicable

☐ Married ☐ Single ☐ Widowed

☐ Separated ☐ Divorced ☐ Do you live alone? ☐ Yes ☐ No

B. Occupation

1. Are you currently employed? If so, what is your occupation?

   _____

2. If retired, or not working, what was your occupation?

   _____

C. Alcohol Use

1. Do you drink alcoholic beverages? ☐ Yes ☐ No
2. If yes, what is your daily, weekly, monthly or yearly use?

   _____

D. Litigation

1. Do you have any litigation (lawsuit / lawyer) regarding your condition? ☐ Yes ☐ No

E. Substance / Drug Use

1. Do you use any illegal drugs? (marijuana, ecstasy, cocaine, etc.) ☐ Yes ☐ No
2. If yes, please describe: _____

E. Tobacco Use

1. Do you use tobacco? ☐ Yes ☐ No
2. If yes, what type? ☐ Cigarettes ☐ Chewing Tobacco ☐ Cigars ☐ Other
   How often? How much? _____
3. If you were a tobacco user in the past, what year did you quit? _____

Patient Name: _____

MR#: _____

VI. Review of Systems

Do you now have, or have you had in the past, any of the following?

A. General

Symptom	No	Yes – Please explain
Fever / chills / sweats		
Feeling chronically fatigued (always tired)		
Generalized weakness (all over)		
Unintended weight loss (without trying)		
Difficulty sleeping		

B. Eyes

Blurred vision		
Double vision		
Irritation		
Vision loss		

C. Ears, nose and throat

Earache		
Ringing in ears		
Decreased hearing		
Nasal congestion		
Nosebleeds		
Sore throat		

D. Cardiovascular

Chest pain or pressure		
Heart palpitations		
Fainting		
Shortness of breath with activity		

E. Respiratory System

Cough		
Shortness of breath while at rest		
Excessive mucus		
Coughing up blood		
Wheezing		
Pain with deep breathing		

F. Digestive

Symptom	No	Yes – Please explain
Nausea / vomiting		
Change in bowel habits		
Abdominal pain		
Indigestion / heartburn		
Difficulty swallowing		

G. Genitourinary

Problems with bladder control		
Painful or difficulty urinating		
Blood in urine		
Increase in urinary frequency (more often)		
Abnormal menstrual periods		

H. Musculoskeletal

Back pain		
Joint pain		
Joint swelling		
Muscle cramps		

I. Skin

Repeat or Ongoing Rashes		
Repeat infections		

J. Neurology

Loss of feeling or use of muscle(s)		
Repeat tingling sensations / feelings		
Seizures		
Tremors		
Dizziness		
Short periods of vision loss		
Frequent falls		
Frequent headaches		
Difficulty walking		

Patient Name: _____

MR#: _____

K. Emotional / Mental

Symptom	No	Yes – Please explain
Depression		
Anxiety		
Memory loss		
Claustrophobia (fear of small or crowded places)		
Confusion		

L. Endocrine

Unable to tolerate the heat or cold		
Excessive thirst		
Excessive hunger		
Continued increase in urine output		
Unusual weight change		

M. Heme-Lymph

Abnormal bruising		
Bleeding		

N. Female Reproductive

1. Are you pregnant? □ Yes □ No
2. Are you trying to become pregnant? □ Yes □ No

O. Pharmacy Information

1. Pharmacy Name: _____
   Pharmacy Phone Number: _____
   Pharmacy Address: _____
   _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THESE FORMS. Though time consuming, they will be extremely helpful in providing the best treatment possible.

_____

Patient's Name (Please Print)

_____

Patient's Signature Date