ANN ARBOR NEUROSCIENCE

# Patient History Form

Name:______________________________ Date:______________________________
Contact Phone Number:__________________ Age:________ Date of Birth:________________
Insurance:______________________________________________________________

*Family Doctor/Internist:*
Name:______________________________
Address:______________________________
City, State, Zip______________________________
*Send them a letter? Yes No*

*Who referred you to us?*
Name:______________________________
Address:______________________________
City, State, Zip______________________________
*Send them a letter? Yes No*

Check all that apply:
____Injury on the job ____Auto accident injury ____Receiving disability income
____Legal proceedings pending ____Receiving workers comp. ____Working with a rehab nurse

Imaging: _____MRI _____CT _____X-Ray _____Myelogram _____Bone Scan

Are you employed? ____Yes ____No Occupation______________________________

Does this problem keep you from working? ____Yes ____No (If yes; date last worked:_________)

**Reason for Visit (Chief Complaint):**

______________________________________________________________

**Describe the onset and/or cause of your problem:** Date of onset:_______________

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

**Past Medical History/Family History (check all that apply):**

HEIGHT ______________ WEIGHT ________________

| You | Family | | You | Family | |
|---|---|---|---|---|---|
| ____ | ____ | Heart attack | ____ | ____ | Bleeding problem |
| ____ | ____ | Heart failure | ____ | ____ | Stress test |
| ____ | ____ | High Blood Pressure | ____ | ____ | Cancer |
| ____ | ____ | Stroke | ____ | ____ | Hepatitis |
| ____ | ____ | Kidney disease | ____ | ____ | Pulmonary embolus |
| ____ | ____ | Heart catheterization | ____ | ____ | Blood clotting |
| ____ | ____ | Diabetes | ____ | ____ | High Cholesterol |

**List all past surgeries: (include dates if known)**

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

Reviewed with patient: Physician/PA Signature:____________________________ Date:________________

**Social History:**

| | | | |
|---|---|---|---|
| Are you married? | YES | NO | |
| Females—are you pregnant? | YES | NO | UNSURE |
| Do you smoke? | YES | NO | (# packs__________ for _________ years) |
| Do you use other forms of tobacco? | YES | NO | (What? ________________________) |
| Do you drink alcohol? | YES | NO | (# drinks weekly_________) |

**Allergies to medications and reactions (include tape and latex allergies):**

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Please list all current medications, supplements, vitamins, and herbs you take:**

| Drug | Dose | How many times taken daily |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

****Specifically have you taken Aspirin or any Aspirin-like product (Motrin, Advil, Nuprin) in the last 10 days? **YES** **NO**

What medication did you take?_________________ When?__________________

**Review of Systems (please check any that apply):**

| YES | NO | **General** |
|---|---|---|
| ____ | ____ | fever |
| ____ | ____ | weight gain |
| ____ | ____ | weight loss |
| ____ | ____ | sexual dysfunction |
| ____ | ____ | cancer |
| ____ | ____ | HIV |

| YES | NO | **Ears, Nose, Throat** |
|---|---|---|
| ____ | ____ | cold symptoms |
| ____ | ____ | headache |
| ____ | ____ | nasal drainage |
| ____ | ____ | sore throat |
| ____ | ____ | hearing loss |

| YES | NO | **Eyes** |
|---|---|---|
| ____ | ____ | sharp vision |
| ____ | ____ | glaucoma |
| ____ | ____ | cataracts |
| ____ | ____ | blindness |

| YES | NO | **Heart** |
|---|---|---|
| ____ | ____ | chest pain (angina) |
| ____ | ____ | palpitations |
| ____ | ____ | irregular heart beat |
| ____ | ____ | poor circulation |
| ____ | ____ | valve disease |

| YES | NO | **Lungs** |
|---|---|---|
| ____ | ____ | shortness of breath |
| ____ | ____ | cough |
| ____ | ____ | sleep apnea |

| YES | NO | **Lymph Nodes** |
|---|---|---|
| ____ | ____ | enlarged lymph nodes |

| YES | NO | **Stomach (GI)** |
|---|---|---|
| ____ | ____ | abdominal pain |
| ____ | ____ | diarrhea |
| ____ | ____ | constipation |
| ____ | ____ | nausea/vomiting |
| ____ | ____ | reflux |
| ____ | ____ | liver cirrhosis |
| ____ | ____ | loss of bowel control |

| YES | NO | **Renal (Urinary)** |
|---|---|---|
| ____ | ____ | renal failure |
| ____ | ____ | difficulty urinating |
| ____ | ____ | urgency |
| ____ | ____ | frequency |
| ____ | ____ | UTI |
| ____ | ____ | kidney stones |
| ____ | ____ | loss of bladder control |
| ____ | ____ | blood in urine |

| YES | NO | **Muscle/ Bone** |
|---|---|---|
| ____ | ____ | arthritis |
| ____ | ____ | osteoporosis |
| ____ | ____ | lupus |
| ____ | ____ | rheumatoid arthritis |
| ____ | ____ | sciatica |
| ____ | ____ | radiculopathy |

| YES | NO | **Skin** |
|---|---|---|
| ____ | ____ | rash |
| ____ | ____ | cancer |
| ____ | ____ | infection |
| ____ | ____ | psoriasis |
| ____ | ____ | eczema |
| ____ | ____ | ulcers |

| YES | NO | **Brain/ Nerves** |
|---|---|---|
| ____ | ____ | seizure |
| ____ | ____ | memory loss |
| ____ | ____ | paralysis |
| ____ | ____ | mini stroke |
| ____ | ____ | facial drooping |
| ____ | ____ | slurred speech |

| YES | NO | **Blood Disorders** |
|---|---|---|
| ____ | ____ | Sickle cell anemia |
| ____ | ____ | VonWillebrands |
| ____ | ____ | Hemophilia |
| ____ | ____ | Excessive bleeding |
| ____ | ____ | Easy bruising |

| YES | NO | **Sleep/Psychological** |
|---|---|---|
| ____ | ____ | Insomnia |
| ____ | ____ | excessive tiredness |
| ____ | ____ | anxiety |
| ____ | ____ | depression |
| ____ | ____ | manic depression |