CLEAR LAKE BRAIN AND SPINE INSTITUTE

NEW PATIENT MEDICAL HISTORY

DATE: _______________ NAME: ______________________________________ DATE OF BIRTH: __________________

TOBACCO USE: YES/NO HOW MUCH? _______/DAY/MONTH HOW LONG? _________ QUIT DATE ___________

ALCOHOL USE: YES/NO HOW MUCH PER DAY/WEEK/MONTH? _________

CAFFIENE (COFFEE, TEA, SODAS) PER DAY _______________

CURRENT MEDICATIONS: ____

____

____

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES)

____

____

____

REVIEW OF SYSTEMS – PLEASE WRITE BY EACH LINE "Y" OR "N" AS THEY RELATE TO YOUR HEALTH:

CONSTITUTIONAL: YES/NO
- Weight Loss _______
- Fatigue _______
- Fever _______

EYES: YES/NO
- Glasses/Contacts _______
- Eye Pain _______
- Double Vision _______
- Cataracts _______

EAR, NOSE, THROAT: YES/NO
- Difficulty Hearing _______
- Ringing in Ears _______
- Vertigo _______
- Sinus Trouble _______
- Nasal Stiffness _______
- Frequent Sore Throat _______

CARDIOVASCULAR: YES/NO
- Murmur _______
- Chest Pain _______
- Palpitations _______
- Fainting Spells _______
- Shortness of Breath _______
- Difficulty lying flat _______
- Swelling Ankles _______

RESPIRATORY: YES/NO
- Cough _______
- Coughing Blood _______
- Wheezing _______
- Chills _______

GASTROINTESTINAL: YES/NO
- Heartburn/Reflex _______
- Nausea/Vomiting _______
- Constipation _______
- Change in BMs _______
- Diarrhea _______
- Jaundice _______
- Abdominal Pain _______
- Black or Bloody BM _______

GENITOURINARY: YES/NO
- Burning/Frequency _______
- Blood in Urine _______
- Erectile Dysfunction _______
- Abnormal Discharge _______
- Bladder Leakage _______

ALLERGIC/IMMUNOLOGIC: YES/NO
- Hives/Eczema _______
- Hay Fever _______

HEMATOLOGY/LYMPH: YES/NO
- Easy Bruising _______
- Gums Bleed Easily _______
- Enlarged Glands _______

MUSCULOSKELETAL: YES/NO
- Joint Pain/Swelling _______
- Stiffness _______
- Muscle Pain _______
- Back Pain _______

SKIN: YES/NO
- Rash/Sores _______
- Lesions _______
- Itching/Burning _______

NEUROLOGICAL: YES/NO
- Loss of Strength ________
- Numbness ________
- Headaches ________
- Memory Loss ________

ENDOCRINE: YES/NO
- Loss of hair ________
- Heat/Cold Intolerance ________

PSYCHIATRIC: YES/NO
- Anxiety/Depression: ________
- Mood Swings ________
- Difficult Sleeping ________