NORTHWEST BRAIN AND SPINE • PATIENT MEDICAL HISTORY

Name:_____ Date:_____

Why are you here today?_____

Where exactly is your worst pain located?_____

How long have you had pain?_____

On a scale of 1 – 10, rate your pain:_____

Is this appointment due to an on-the-job accident? Or motor vehicle accident? Date of Injury:_____

CURRENT MEDICATIONS:

_____
_____
_____

MEDICATION ALLERGIES:

_____
_____
_____

BLOOD THINNERS: ☐YES ☐NO If yes, which medication?_____

DAILYASPRIN PRODUCTS: ☐YES ☐NO If yes, which medication?_____

LIST ALL PREVIOUS SURGERIES & DATES:

_____
_____
_____

CURRENT MEDICAL CONDITIONS:

_____
_____
_____

DOB:_____ Marital Status: ☐M ☐W ☐S ☐D Height:_____ Weight:_____

Age:_____ Job Titles:_____ Recreation you enjoy:_____

Do you drink alcohol? ☐ YES ☐ NO How much per day?_____ Per week?_____

Do you Smoke? YES ☐ NO ☐ How much per day?_____ Per week?_____

Father's Name	Current Health Condition	Age	Mother's Name	Current Health Condition	Age

FAMILY HEALTH HISTORY:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Heart Disease	☐	☐	Kidney Disease	☐	☐	Diabetes	☐	☐	Epilepsy
☐	☐	Headaches	☐	☐	Thyroid	☐	☐	Cancer	☐	☐	Other (specify)_____

PLEASE CHECK YES OR NO IF YOU EXPERIENCE OR HAVE ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Headaches	☐	☐	Kidney Disease	☐	☐	High Cholesterol	☐	☐	Back Pain/injury
☐	☐	Heart Disease	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐	Asthma
☐	☐	Heart Attack	☐	☐	Thyroid	☐	☐	Arthritis	☐	☐	Claustrophobia
☐	☐	Lung Disease	☐	☐	Diabetes				☐	☐	Cancer(type)_____