SEMMES MURPHEY
NEUROLOGIC & SPINE INSTITUTE
Excellence in Neuroscience

Name: ______________________ **Date:** ____________

Age: ____________ **Height:** ____________ **Weight:** ____________

MEDICAL HISTORY

CHIEF COMPLAINT *(Describe your problem and what treatment you have had):* ____________

What doctors have you seen for this problem, and what tests have you had? ____________

PAST MEDICAL HISTORY *(Have you ever been diagnosed with the following)*

High Blood Pressure ______
Heart Disease ______
Lung Disease ______
Asthma ______
Blood Vessel Blockage ______
Blood Disorders ______
Lupus ______
Ulcers ______
Migraines ______
Diabetes Mellitus ______
Other Problems *(please explain)* ____________

Cancer ______
Stroke ______
Aneurysm (brain) ______ (abdominal) ______
Arthritis ______
Kidney Disease ______
Hepatitis ______
HIV ______
Depression/Anxiety ______
Alcoholism ______
Elevated Cholesterol ______

LIST ALL SURGERIES:

____

DRUG ALLERGIES & REACTIONS *(If allergic, list your reaction to the drug beside the drug name.)*

Iodine ______
Latex ______
Tape ______
Foods ______
Other ______

Penicillin ______
Sulfa ______
Codeine ______
Xylocaine or local anesthesia ______
Other ______

Demerol ______
Morphine ______
Tetanus ______
Other ______

MEDICATIONS AND VITAMINS *(including over the counter medications)*

Name	Strength	How Often?

Use the back of this sheet if you need more space

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REVIEW OF SYSTEMS *(Have you had or are you having problems with any of the following in the past year?)*

General / Constitutional
_______ Fever
_______ Chills
_______ Sweats
_______ Weight Loss
_______ Sleep Disturbance
_______ Feeling Run-down

Eyes
_______ Blurry Vision
_______ Blindness
_______ Eye Pain
_______ Eye Discharge
_______ Sensitivity to Light

Ears/Nose/Throat
_______ Hearing Loss
_______ Earache
_______ Ear Discharge
_______ Ringing in Ears
_______ Nosebleeds
_______ Sore Throat
_______ Hoarseness
_______ Trouble Swallowing

Cardiovascular
_______ Chest Pain
_______ Palpitations
_______ Fainting
_______ Ankle Swelling
_______ Breathing Difficulty

Respiratory
_______ Cough
_______ Wheezing
_______ Coughing Up Blood
_______ Shortness of Breath
_______ Sleep Apnea

Gastrointestinal
_______ Constipation
_______ Indigestion
_______ Nausea/Vomiting
_______ Diarrhea
_______ Change in Bowel Habits
_______ Abdominal Pain
_______ Dark Tarry Stool
_______ Bleeding per Rectum
_______ Jaundice

Genitourinary
_______ Urinary Frequency
_______ Bladder Control
_______ Painful Urination
_______ Impotence
_______ Sexual Dysfunction
_______ Abnormal Menstrual Period
_______ Pelvic Pain

Musculoskeletal
_______ Joint Pain
_______ Joint Swelling
_______ Arthritis
_______ Muscle Pain
_______ Muscle Weakness
_______ Stiffness

Skin
_______ Rash
_______ Itching
_______ Dryness
_______ Suspicious Lesions

Neurologic
_______ Stroke
_______ Numbness
_______ Paralysis
_______ Seizures
_______ Migraines
_______ Tremors
_______ Memory Loss

Psychiatric
_______ Depression
_______ Anxiety
_______ Suicidal Thoughts
_______ Mental Disturbance
_______ Hallucinations
_______ Paranoia

Endocrine
_______ Cold Intolerance
_______ Heat Intolerance
_______ Excessive Thirst
_______ Excessive Urination
_______ Diabetes
_______ Thyroid Dysfunction

Hematologic/Lymphatic
_______ Abnormal Bruising
_______ Bleeding
_______ Enlarged Lymph Nodes

Allergic/Immunologic
_______ Rashes
_______ Hay Fever
_______ Persistent Infections
_______ HIV Exposure

Other (describe below):
____
____

FAMILY HISTORY *(List the family member--mother, father, brother, sister only--who had condition)*

High Blood Pressure _____
Cancer _____ Type:______________________________
Stroke _____
Lung Disease _____
Mental Retardation _____
Heart Disease _____
Migraines _____
Diabetes _____
Neurological Illness _____
Other Medical Conditions: ____
____

SOCIAL HISTORY

Do you use tobacco (cigarettes/pipe/chewing tobacco/cigars)?
_____ Yes _____ No _____Quit >> When? _______ If so, how much?_______________
Do you use alcohol regularly? ______________ If so, how much? _______________
What is your occupation? ____
Are you: _____ right handed, _____ left handed, _____ambidextrous
Are you: _____ Single _____ Married _____ Widowed _____ Divorced
Have you travelled outside the US in the last year? When? Where? _______________
Are there any lawsuits pending on your neurologic condition? _______________
If so, please provide your attorney's name, address and phone number: _______________
____

_______________________________ *Patient Signature*

_______________ *Date*