**GOLDEN TRIANGLE NEUROCARE, LLP**
**PATIENT MEDICAL HISTORY**

**Date completed**_____

**NAME:**_____ **SS#**_____
**ADDRESS:**_____
**CITY:**_____ **STATE:**_____ **ZIP**_____
**AGE:**_____ **DATE OF BIRTH**_____ **SEX: M**____ **F**_____
**PHONE: HOME**_____ **WORK**_____ **CELL**_____
**HEIGHT:**_____ **WEIGHT:**_____
**MARITAL STATUS: (Circle One):**
**SINGLE MARRIED DIVORCED WIDOWED**
**PRESENT OCCUPATION:**_____ **HOW LONG?**_____
**EMPLOYER'S ADDRESS:**_____
**CITY:**_____ **STATE**_____ **ZIP**_____
**EMPLOYER'S PHONE NUMBER:**_____
**PREVIOUS OCCUPATION:**_____ **HOW LONG?**_____
**Who sent you to see a Neurosurgeon?**_____
**Please list all of your doctors names and addresses:**

_____

_____

**What problem/symptoms are you having?**_____
**When was the first time you had this problem?**_____
**Was it associated with an injury?**_____
**Where is the problem?**_____
**How long have you had this problem?**_____
**What makes it worse?**_____
**What makes it better?**_____
**Have you ever had the same or similar problem?**_____
**Describe your complaints using as much detail as needed. (Use the back of sheet if needed)**

_____

_____

_____

_____

| Previous Treatment: | (Circle one) | | How Long? | Did treatment help? | |
|---|---|---|---|---|---|
| Bed rest? | Yes | No | _____ | Yes | No |
| Chiropractic? | Yes | No | _____ | Yes | No |
| Manipulations? | Yes | No | _____ | Yes | No |
| Traction? | Yes | No | _____ | Yes | No |
| Williams Exercises? | Yes | No | _____ | Yes | No |
| Braces? | Yes | No | _____ | Yes | No |
| Physical Therapy? | Yes | No | _____ | Yes | No |
| Acupuncture? | Yes | No | _____ | Yes | No |
| Medications? | Yes | No | _____ | Yes | No |
| Epidural injections | Yes | No | _____ | Yes | No |

 **Patient name**_____

**How often is the pain present? (Circle One)** **All of the time** **Once a day**
**Most of the time** **Once a week**
**Some of the time** **Once a month**

**Have you had to give up any of the activities you used to do since you have had the pain?**

**Yes No If so, what were these activities?**_____

| **Is pain increased with:** | | **(Circle One)** |
|---|---|---|
| **Bowel Movements** | **Yes** | **No** |
| **Urination** | **Yes** | **No** |
| **Sexual Activity** | **Yes** | **No** |
| **Pushing** | **Yes** | **No** |
| **Bending** | **Yes** | **No** |
| **Lifting** | **Yes** | **No** |
| **Walking** | **Yes** | **No** |
| **Coughing** | **Yes** | **No** |
| **Sneezing** | **Yes** | **No** |
| **Sitting** | **Yes** | **No** |
| **Standing** | **Yes** | **No** |
| **Climbing Stairs** | **Yes** | **No** |
| **Turning/rotation of back or neck** | **Yes** | **No** |

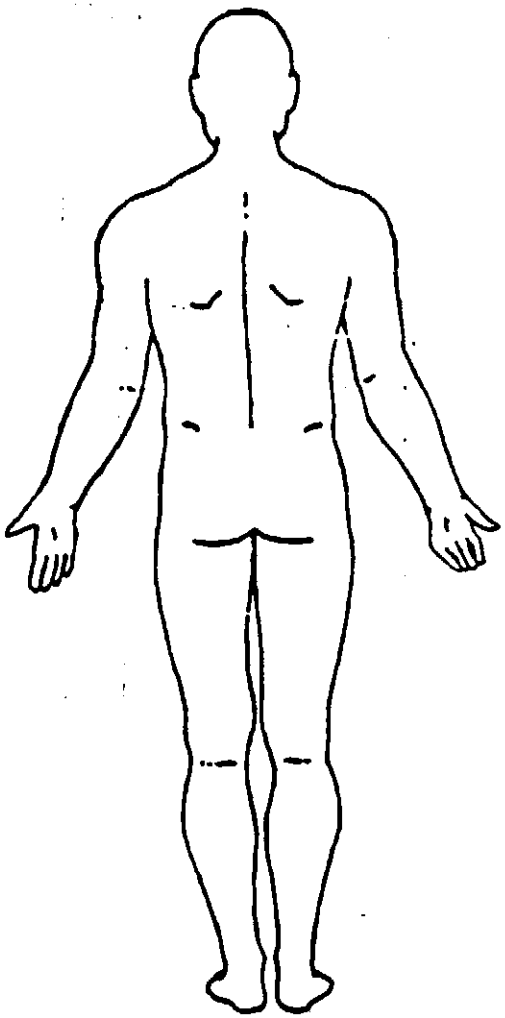
**Please list all medications you are currently taking:** _____
_____
_____
_____
_____

**LIST ANY MEDICATION ALLERGIES:**_____
_____
**If you have tried medications, what were they? Please list all you have tried.**_____
_____
**Are you taking any vitamins, herbal or dietary supplements? Please list** _____
_____
**Are you taking or have you taken St John's Wort?**_____**If so, when?**_____

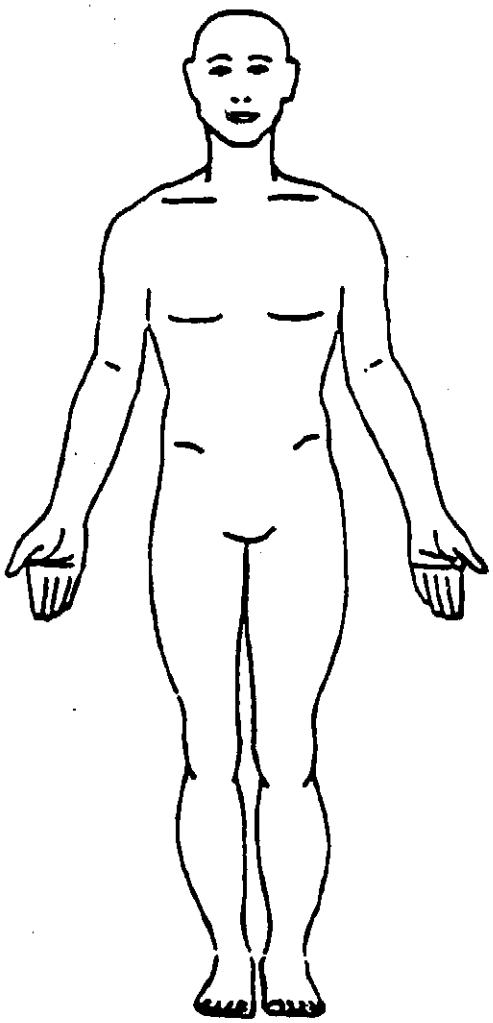
Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol for each. Include ALL affected areas.

| ACHE | NUMBNESS | PINS & NEEDLES | BURNING | STABBING |
|---|---|---|---|---|
| **** | oooo | xxxx | #### | ///// |

LEFT



RIGHT



LEFT

**Please circle any of the following that you have ever had:**

| | |
|---|---|
| High blood pressure | Childhood Infections: |
| Diabetes | Mumps |
| Heart trouble | Measles |
| Cancer | Chicken Pox |
| Liver trouble (Hepatitis) | Polio |
| Arthritis | Rheumatic Fever |
| Kidney or Bladder Disease | Asthma |
| Syphilis (bad blood) | |
| Gonorrhea | |
| Gout | |
| Malaria | |
| Tuberculosis | |

**Have you ever been hospitalized for any of the above medical conditions?**_____

_____

_____

**Do you smoke?**_____**If yes, packs per day?**_____

**Do you drink?**_____ **If yes, to what extent?**_____

**What routine medications do you take for your medical problems?**_____

_____

_____

**Please list any operations and injuries you have had in the past. Include what kind of surgery, name of doctor, where and when the procedure was done.**_____

_____

_____

_____

**Date of your last physical examination?**_____

**Do you have any blood relatives who have had the following: Please circle.**

| | |
|---|---|
| Hay fever or asthma | Heart trouble |
| High blood pressure | Diabetes |
| Cancer | Nervous breakdown |
| Tuberculosis | Bleeding tendencies |
| Epilepsy or convulsive disorder | Nervous disorder |

**Any other serious disease? Please list.**_____

 Patient Name_____

Have you had a recent x-ray Yes No If yes, what body part and when and where was xray taken?_____

Have you had a CT Scan? Yes No If yes, what body part and when and where was CT done?_____

Have you had an MRI? Yes No If yes, what body part and when and where was MRI done?_____

Have you had a Myelogram? Yes No If yes, when and where was myelogram done?_____

Have you had an EMG? Yes No If yes, when and where was the EMG done?_____

Have you had a cerebral angiogram? Yes No If yes, when and where was this done?_____

Do you have a worker's compensation claim pending?_____
Is there a lawyer who would want a report of your visits to our clinic?_____If yes, list name and address:_____

Please list other lawyers you have dealt with:_____

Please list your pharmacy name and phone number:_____

Please list emergency phone numbers where you can be reached:_____

_____ _____
Patient's Signature Date