Neurosurgery Associates, LLC

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INITIAL MEDICAL HISTORY FORM

Name: _____ Age_____ Today's Date_____

□ Right Handed □ Left Handed Stated Height_____ Weight_____

Email: _____ **Cell Phone**:_____

Referring Physician_____

Address_____Phone_____

Family Physician_____

Address_____Phone_____

PAIN MANAGEMENT or other physicians you have seen for this problem _____

Address_____Phone_____

REASONS FOR THIS OFFICE VISIT

Chief Complaint: _____

- **Pain:** Where is your pain? _____

Please rate severity of your pain on average *(0 = no pain, 10 = worst possible pain):*

0 1 2 3 4 5 6 7 8 9 10

At best 0-10 _____ at worst 0- 10 _____

How long have you had this pain? _____

Is this a work-related injury? □ Y □ N Is this from a Motor Vehicle Accident? □ Y □ N Lawyer? □ Y □ N

Date of injury (if applicable): _____ what happened? _____

_____

What makes the pain better? (Check all that apply)

□ Pain pills □ Rest □ leaning forward □ other _____

What makes the pain worse? (Check all that apply):

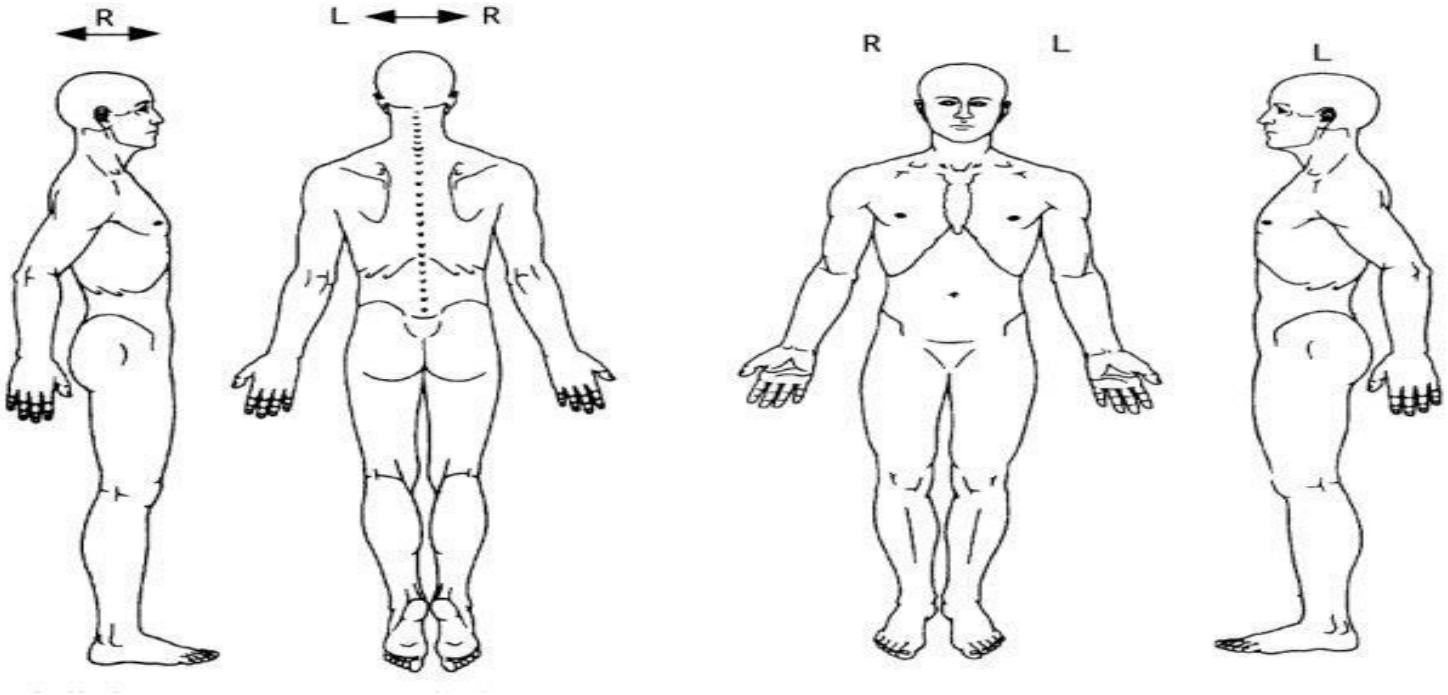
□ Physical activity □ prolonged standing □ Coughing □ other_____

- **Any Numbness:** □ Y □ N Where?

_____

- **Any Weakness:** □ Y □ N Where? _____
- **Any Burning:** □ Y □ N Where? _____
- **Any urine incontinence?** □ Y □ N any **bowel incontinence?** □ Y □ N **any sexual dysfunction?** □ Y □ N

Please **SHADE** in area(s) where your **PAIN and X where the NUMBNESS** is located:



- Is your **pain** constant? □ **Y** □ **N**
- **IMAGING STUDIES you have had so far**? **Body part:**

□ X-rays _____

□ MRI _____

□ CT scan _____

□ EMG (nerve study) _____

□ Other_____

- **CONSERVATIVE TREATMENTS** you had for this problem? (check all that apply):

□ Pain Medications □ Steroid Injections □ Physical Therapy □ Chiropractic Care □ TENS Unit

□ Regenerative Medicine _____ □ Acupuncture _____

□ Anti-inflammatories □ Other: _____

Which of these treatments helped? _____

- **SURGICAL TREATMENTS** you have had for this problem?

  List procedure(s) _____

REVIEW OF SYMPTOMS (past 30 days)

Have you **recently** had problems with any of the following, if so please check all that apply:

Constitutional
- ❑ Fever
- ❑ Unintentional weight loss
- ❑ Excessive fatigue
- ❑ Night sweats
- ❑ Loss of appetite
- ❑ Insomnia

Neurological
- ❑ Fainting
- ❑ Dizziness/lightheadedness
- ❑ Seizures
- ❑ Tension headaches
- ❑ Migraine headaches
- ❑ Problems with your memory
- ❑ Disorientation
- ❑ Difficulty with speech
- ❑ Inability to concentrate
- ❑ Double or blurred vision
- ❑ Face weakness
- ❑ Lack of coordination in arms/legs

Musculoskeletal
- ❑ Arm or leg weakness
- ❑ Arm or leg pain
- ❑ Neck pain
- ❑ Back pain
- ❑ Joint swelling
- ❑ Joint stiffness
- ❑ Joint pain
- ❑ Muscle cramps/spasms

Eyes, Ear, Nose, Throat, Mouth
- ❑ Hearing loss
- ❑ Ringing in ears
- ❑ Eye infections
- ❑ Eye injuries
- ❑ Ear pain
- ❑ Ear infections
- ❑ Balance disturbance (vertigo/spinning)
- ❑ Lightheadedness
- ❑ Inability to smell
- ❑ Sinus headaches
- ❑ Trouble swallowing

Cardiovascular
- ❑ Chest pain
- ❑ Palpitations
- ❑ Irregular pulse
- ❑ Heart murmur
- ❑ Swelling in the ankles

Respiratory
- ❑ Wheezing
- ❑ Frequent cough
- ❑ Shortness of breath
- ❑ Coughing up blood

Gastro-Intestinal
- ❑ Heartburn
- ❑ Nausea
- ❑ Vomiting
- ❑ Jaundice
- ❑ Abdominal pain
- ❑ Ulcers or gastritis
- ❑ Bowel incontinence

Genitourinary
- ❑ Urinary tract infection
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Difficulty starting/stopping stream
- ❑ Urine incontinence

Integumentary
- ❑ Skin rash
- ❑ Change in skin color
- ❑ Change in hair or nails

Psychiatric

- ❑ Depression
- ❑ Anxiety
- ❑ Trouble sleeping

Endocrine

- ❑ High blood sugar
- ❑ Cold intolerance
- ❑ Change in appetite
- ❑ Excessive thirst or urination

Hematologic/Lymphatic

- ❑ Anemia
- ❑ Bleeding easily
- ❑ Bruising easily
- ❑ Persistent swollen glands/lymph nodes

Allergic/Immunologic

- ❑ Food allergies

If yes, list

_____

- ❑ Seasonal allergies

PAST MEDICAL HISTORY (like diabetes, Rheumatoid arthritis, etc):

- _____
- _____

CURRENT MEDICATIONS/SUPPLEMENTS	Dose	Frequency

- Do you currently take **aspirin** or products containing **aspirin**? □ Yes □ No
- **ALLERGIES**: _____ OR ☐ **NKDA**
- **OTHER ALLERGIES:** (like **Latex, Metal**, or contrast dye)
  _____

PAST SURGERIES / HOSPITALIZATION	Year	Doctor	Complications

FAMILY MEDICAL HISTORY

- Are there any diseases that run in your family? (like Diabetes or Alzheimer's etc):_____
  _____

Family Member	Alive	Deceased	Age	Health Status or Cause of Death
Father				
Mother				

SOCIAL HISTORY

- **Marital Status** _____
- **Occupation** _____

  Are you currently working? □ Y □ N □ Full-time □ Part-time

  If not working, when was the last day you worked? _____

  Are you on disability? □ Y □ N If so, for what reason? _____

- **Tobacco**:
  - ❑ Yes, I smoke _____ packs of cigarettes (chew tobacco) per day and have for the past _____ years.
  - ❑ No, I have never smoked cigarettes.
  - ❑ No, used to smoke, but I quit _____ years ago.

· **Alcohol**: How many alcoholic beverages do you consume per week? _____

What type _____

- **Recreational Drug Use?** □ Yes □ No

What type _____

- Are you at risk for AIDS or Hepatitis C? (e.g. past blood transfusion) □ Y □ N Explain:_____
- Any metal in your body? □ Yes □ No ****Pacemaker** □ Yes □ No Hearing Aid □ Yes □ No
- Are you claustrophobic? □ Yes □ No
- Do you have a sleep apnea? □ Yes □ No
- Is there any SPECIAL information we should know about you that has not already been asked? (Examples: **Bleeding or clotting disorder**, Jehovah's Witness, etc.):_____

How did you hear about us?

- ☐ Facebook
- ☐ Health Grades or other review site
- ☐ Google
- ☐ Your Referral Physician Or PCP
- ☐ Referred by a patient
- ☐ Online Videos
- ☐ Website: (drshehadi.com)
- ☐ Church Bulletin
- ☐ Other: _____

All the information provided above is accurate and complete to the best of my knowledge as the patient.

PATIENT SIGNATURE _____Date _____