

NeuroScience Associates
PATIENT HEALTH HISTORY

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Patient Height _____ Patient Weight _____

Chief Complaint/ Reason for today's visit? _____

Current problem is the result of a(n): Check all that apply

Car Accident Work Accident Accident Other _____

Date of onset _____

Past Medical History

Please list any medical conditions (i.e hypertension, diabetes, etc) or major injuries:

Surgical History

Surgeries/Hospitalizations	Year	Complications

Have you ever had an antibiotic resistant infection? Yes No

If Yes, was it MRSA or VRF? (Please circle)

Have you ever had problems with anesthesia? Yes No

Do you take Aspirin? Yes No If Yes, how often : _____

Medications

Current Medications Including Over the Counter	Dose	Frequency

NeuroScience Associates

Patient Name: _____

ALLERGIES/TYPES OF REACTIONS

Please circle: **Latex** Yes No **Iodine** Yes No **Shellfish** Yes No **Asthma** Yes No

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

SOCIAL HISTORY

Do you have children? Yes No How many? _____

Do you live alone? Yes No Who lives with you? _____

Do you smoke? Yes, I've smoked _____ packs of cigarettes per day for _____ years.

Yes, I smoke cigars or a pipe.

No, I have never smoked.

No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____ years.

Do you drink alcohol? No, never (or rarely) No, but I used to

Yes Daily 1 or more times a week 1 or more times a month

Are you at risk for AIDS (e.g., sexual orientation, drug abuse, previous blood transfusion)?

No Yes, please explain _____

Deferred by patient: Signature _____