Name:
DOB:
Chart:
Age:
Date:

Culicchia Neurological Clinic Patient History

Name:________________ Age: ______ Date of Birth: ________ Height: ______ Weight: ______

Name of Physician who Referred you to us: ________________

Reason for Visit:________________ How Long:________________

Onset of Pain:
- ☐ Gradual
- ☐ Fairly Acute
- ☐ Non-Traumatic
- ☐ Traumatic
  - Motor Vehicle Accident ________ Date
  - Personal Injury ________ Date
  - Work Injury________ Date

☐ Previous Traumatic Injury
- Type ________
- Date ________

What type of work do you do: ________________ Are you currently disabled? ☐ Yes ☐ No

CURRENT MEDICATIONS (List all, including non-prescription medications)

List any allergies to medications, I. V. dye or foods: ________________

PHARMACY INFORMATION
PHARMACY NAME________________
ADDRESS________________
CITY________ STATE ______ ZIP______ PHONE# (   ) ________

PREVIOUS HOSPITALIZATIONS AND ANY SURGERIES:

Do not include normal pregnancies. Indicate the year of the hospitalization and reason.

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

Past Medical History

☐ High blood pressure	☐ Migraine headache	☐ Anemia	☐ Alcohol abuse
☐ Heart disease	☐ Seizure disorder	☐ Blood clots	☐ Mental illness
☐ Diabetes	☐ Alzheimers / Dementia	☐ Bleeding disorder	☐ Drug abuse
☐ High cholesterol	☐ Arthritis	☐ Osteoporosis	☐ Depression
☐ Stroke	☐ Rheumatoid Arthritis	☐ Glaucoma	☐ Cancer
☐ Kidney disease	☐ Bronchitis / Emphysema	☐ Asthma	☐ Thyroid trouble
☐ Acid reflux / Ulcer	☐ Liver disease / Hepatitis	☐ HIV / AIDS	☐ Cancer ________
☐ Gout	☐ Aneurysm	☐ Vascular disease	☐ Macular degeneration

Social History

Marital Status
- ☐ Married
- ☐ Divorced
- ☐ Single
- ☐ Widowed

Smoking Status
- ☐ Current smoker, daily use Start Date:________
- ☐ Current smoker, not daily Start Date:________
- ☐ Never smoker
- ☐ Former smoker Start Date:________ Quit Date: ________

Alcohol Status
- ☐ Daily use
- ☐ Social use
- ☐ None

Name:
DOB:
Chart:
Age:
Date:

Family History
Have any of your relatives had:

	Father	Mother	Sibling	Children
Alcohol abuse	☐	☐	☐	☐
Alzheimers / Dementia	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Aneurysm	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐
Blood clots	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Drug abuse	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐
Migraine headache	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐
Seizure disorder	☐	☐	☐	☐
Stroke	☐	☐	☐	☐

Review of Systems

Constitutional
☐ Fever and chills
☐ Weakness or fatigue
☐ Recent weight loss

Eyes
☐ Blurred vision
☐ Double vision

Ears, Nose, Mouth, Throat
☐ Trouble hearing
☐ Tinnitus, noise, ringing in ears
☐ Ear pain
☐ Ear infection or drainage
☐ Dizziness, vertigo, unsteadiness
☐ Stuffy nose
☐ Frequent colds
☐ Hay fever
☐ Sinus trouble
☐ Frequent nosebleeds
☐ Frequent sore throats
☐ Pain near teeth or mouth
☐ Hoarseness or voice change
☐ Difficulty with swallowing
☐ Lumps in neck
☐ Swollen glands in neck
☐ Pain in neck

Cardiovascular
☐ Heart trouble
☐ Palpitations

Respiratory
☐ Cough
☐ Asthma or wheezing
☐ Shortness of breath

Allergic
☐ Hay fever or dust / mold allergy
☐ Food sensitivity or intolerance

Gastrointestinal
☐ Heartburn or acid reflux
☐ Nausea or vomiting
☐ Diarrhea
☐ Ulcers
☐ Loss of bowel control
☐ Constipation

Genitourinary
☐ Frequent urination
☐ Painful urination
☐ Loss of bladder control

Musculoskeletal
☐ Joint pain or stiffness
☐ Muscle stiffness
☐ Muscle weakness
☐ Back pain

Integumentary
☐ Skin rashes
☐ Skin wounds
☐ Excessive skin dryness / itchiness

Neurological
☐ Headaches
☐ Numbness in face, arms, legs
☐ Seizures
☐ Weakness of arms or legs
☐ Blackouts or fainting
☐ Trouble speaking
☐ Confusion or memory loss
☐ Falling

Psychiatric
☐ Nervousness or increased stress
☐ Sleep problems
☐ Excessive moodiness or worry

Endocrine
☐ Heat or cold intolerance
☐ Excessive thirst or urination

Hematologic
☐ Easy bruising or bleeding

☐ Chemical sensitivity

Do you use coffee, tea or caffeinated beverages? _______YES _______NO If YES…_______cups/day
When was the last time you received your Tetanus Diphtheria (Td) Booster? ______________________________(Date / Year)
Dominant Hand? ☐ Right ☐ Left
For patients over 65, have you had a Pneumonia Vaccination? ☐ Yes ☐ No
Have you had a flu vaccine? ☐ Yes ☐ No
Do you have an Advance Directive (Living Will)? ☐ Yes ☐ No

PLEASE MAKE SURE THAT YOU HAVE COMPLETED ALL AREAS OF THIS FORM (BOTH PAGES) AND THAT YOU SIGN BELOW. THANK YOU.

PATIENT'S SIGNATURE:	**DOB:**	**DATE:**