GLN MEDICAL HEALTH HISTORY FORM

GENERAL INFORMATION

Name:				Phone (Home):
Address:	City:	State:	Zip code:	Phone (Work):
Date of birth:	Age:	Sex: M F	Marital Status: S M W D	Phone (Cell):
Height: _____' ______"	Weight: ______ lbs.	Right-handed ____ or Left-handed _____		
Family Physician Name:				Phone Number:
Who referred you to our office?:				Phone Number:
Occupation & Employer				Social Security Number:
Insurance (Company name and ID numbers):				

Are you currently on disability?: Y____ N____ (If "Y" please indicate below which type)

Workers Compensation _____ Social Security Disability _____ Other (specify):

Auto _____ Lawsuit _____

Are you currently involved in a lawsuit? Y____ N____

NEUROSURGICAL HISTORY

What problem brought you to our office today?

What were you doing when this problem occurred?

How long have you experienced this problem (in terms of days, months or years)?

What type of work do you do?

Have you missed work due to this problem?: Y ____ N ____ How much? __________

Does your work involve any of the following:

Repetitive bending_____ Heavy lifting ______

Frequent use of hands or arms _____ Twisting ______

Is this problem associated with:

Numbness Tingling Weakness

(Please circle all that apply and indicate what part of your body is affected):

Have you had this problem in the past? Y _____ N _____

If so, when? __________________

Today's Date: ______________________________________

Describe the location of any pain you are having:

Describe the type of pain you are experiencing:

Sharp____ Burning _____ Pressure _____

Dull____ Shooting _____ Other ____________________

What worsens the pain?:

Standing ____ Climbing stairs ____ Lifting _____ Coughing or sneezing _____

Sitting ____ Walking ____ Bending ____ Straining ____

Twisting _____

What relieves the pain or discomfort?:

Have you experienced any of the following?:

Impaired vision Y____ N____ Double vision Y ____ N ____

Impaired hearing Y____ N____ Loss of smell Y ____ N ____

Numbness Y____ N____ Tingling Y____ N____

Facial nerve injury or paralysis? Y ____ N ____ Blackout spells or seizures? Y _____ N _____

Concussion or severe head injury? Y _____ N _____

Previous diagnostic tests performed (give dates and medical facility, if known):

Spine X-rays: CT Scan:

Skull X-rays: MRI:

Myelogram:
(X-ray dye put in spine)

EMG:
(needle test in arms or legs)

Angiogram:
(X-ray dye put in blood vessels)

Treatments attempted:

Decreased activity_____ Heat _____ Chiropractor _____

Bedrest_____ Ice _____ Physical therapy _____

Cortisone/epidural injections _____ Medication _____ Traction _____

PAST / FAMILY / SOCIAL HISTORY

Are you allergic to any medication(s)?: Y _____ N _____

(If yes, please list medication name(s):

Any other allergies?: Y _____ N _____

If yes, please list: (include ***MEDICATIONS, ANESTHESIA, DYE, foods, soaps, latex, other)***

Please list all prior hospitalizations or surgeries:	
Date:	Reason for Hospilization/Surgery:

Please list all other health-related problems, diseases, prior illnesses, or injuries:	
Date:	Health-related problem, disease, illness, or injury:

Childhood Illnesses:

Medications: (Please list all medications you are currently taking, both prescription and non-prescription)

Name of Medication	Dosage	Frequency	Reason for Medication

Which pharmacy do you use most frequently: Phone:

Do you use alcohol? N___ Y___ (If "Y" please list type and amount)

Do you smoke? N ___ Y ___ (If "Y" please list number of packs per day): __________ packs

Do you now, or have you ever, abused alcohol or drugs? N___ Y___ (If "Y" please explain briefly)

Are you on a special diet? N___ Y____(if "Y", please explain)

FAMILY HISTORY: Please describe the health history of your immediate family

Mother: Living: Y ___ N ___ (If deceased, please indicate the cause of death)

Health Problems: N___Y___(If "Y", please describe)

Father: Living: Y ___ N ___ (If deceased, please indicate the cause of death)

Health Problems: N___Y___(If "Y", please describe)

Brother(s): How many? ___ All living? Y ___ N ___ (If deceased, please indicate cause of death)

Health Problems: N___Y___(If "Y", please describe)

Sister(s): How many? ___ All living? Y ___ N ___ (If deceased, please indicate cause of death)

Health Problems: N___Y___(If "Y", please describe)

Children: How many? ___ All living? Y ___ N ___ (If deceased, please indicate cause of death)

Health Problems: N___Y___(If "Y", please describe)

Do any other family members have significant health problems? If so, please describe.

Have you experienced any of the following? If "Y", please indicate the approximate date and explain.			
Y__ N__	Unexplained Fevers	Y__ N__	Stomach Trouble
Y__ N__	Eye Problems	Y__ N__	Liver Problems
Y__ N__	Glasses?	Y__ N__	Ulcer
Y__ N__	Double/blurred vision	Y__ N__	Hepatitis
Y__ N__	Hearing Problems	Y__ N__	Blood in stools
Y__ N__	Chronic Sinusitis	Y__ N__	Nausea / Vomiting
Y__ N__	Hoarseness	Y__ N__	Diarrhea
Y__ N__	Chronic Bronchitis	Y__ N__	Constipation
Y__ N__	Shortness of Breath	Y__ N__	Kidney Trouble
Y__ N__	Difficulty Breathing	Y__ N__	Incontinence
Y__ N__	At night?	Y__ N__	Decreased urination
Y__ N__	With stairs?	Y__ N__	Kidney Stones
Y__ N__	Chronic Cough	Y__ N__	HIV / AIDS
Y__ N__	Bloody Sputum	Y__ N__	Other sexually transmitted disease
Y__ N__	Tuberculosis (TB)		Female Patients:
Y__ N__	Asthma		# of Pregnancies: ________
Y__ N__	Emphysema		Date of LMP: __________
Y__ N__	Rheumatic Fever	Y__ N__	Arthritis
Y__ N__	High Blood Pressure	Y__ N__	Leg Cramps
Y__ N__	Seizures / Epilepsy	Y__ N__	Swelling
Y__ N__	Chest Pain / Pressure	Y__ N__	Anemia
Y__ N__	Heart Murmur	Y__ N__	Leukemia
Y__ N__	Heart Palpitations	Y__ N__	Bleeding Problems
Y__ N__	Mental Illness	Y__ N__	Sickle Cell Anemia
Y__ N__	Depression	Y__ N__	Blood Clots
Y__ N__	Anxiety	Y__ N__	Phlebitis
Y__ N__	Other:	Y__ N__	Varicose Veins
Y__ N__	Numbness	Y__ N__	Pain when walking
Y__ N__	Headaches	Y__ N__	Thyroid Disease
Y__ N__	Migraine Headaches	Y__ N__	Diabetes
Y__ N__	Stroke	Y__ N__	Cancer (List area):
Y__ N__	Childhood Illnesses		Other:

I hereby certify that the above information is correct to the best of my knowledge. I will not hold my physician or any of his staff responsible for any errors or omissions I have made in completing this form.	
Patient's signature:	**Date:**
Reviewed and / or updated by:	
Physician's signature:	**Date:**
Physician's signature:	**Date:**
Physician's signature:	**Date:**
Physician's signature:	**Date:**
Physician's signature:	**Date:**
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