EAST BAY BRAIN & SPINE
MEDICAL GROUP

HEALTH HISTORY

Patient Name:	Patient DOB:	Height:	Weight:

REVIEW OF SYSTEMS

Please review the following conditions. Indicate all conditions that currently apply to you.

- ☐ Unexpected weight loss/gain
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Cough
- ☐ Sore throat
- ☐ Nasal congestion
- ☐ Abdominal pain
- ☐ Pain upon urinating
- ☐ Urinary incontinence
- ☐ Bowel incontinence
- ☐ Confusion
- ☐ Nausea/vomiting
- ☐ Headache
- ☐ Blurry vision
- ☐ Double vision
- ☐ Memory loss
- ☐ Skin rash
- ☐ Joint swelling
- ☐ Leg swelling
- ☐ Enlarged lymph nodes
- ☐ Easy bleeding

MEDICATIONS

Please list all medications and dosage you are currently taking, including over the counter medications. Please also include the length of time you have been taking any narcotic medications.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

List all allergies and associated reactions.

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____

____

PHARMACY

Please provide the name and phone number of your preferred pharmacy so that we may keep this information on file if needed.

Pharmacy Name: ____ Pharmacy Phone Number: ____________

PERSONAL HISTORY

Do you have a history of:			*Month/Year*	*Description*
Asthma	Yes	No	__________	________________________________
Bleeding disorder	Yes	No	__________	________________________________
High Blood Pressure	Yes	No	__________	________________________________
COPD	Yes	No	__________	________________________________
Diabetes Mellitus or Pre-Diabetes	Yes	No	__________	________________________________
Heart Disease	Yes	No	__________	________________________________
Kidney Disease	Yes	No	__________	________________________________
Psychiatric Condition	Yes	No	__________	________________________________
Osteoporosis	Yes	No	__________	________________________________
Strokes	Yes	No	__________	________________________________
Seizures	Yes	No	__________	________________________________
Blood Transfusions	Yes	No	__________	________________________________
Other	Yes	No	__________	________________________________

SURGICAL HISTORY

Please use this space for explanation of medical conditions not listed and for previous surgeries/dates.

____

____

____

ANESTHESIA

Have you ever had a problem with anesthesia? Yes No
If yes, please explain.

____

____

TOBACCO USE

Have you ever smoked? Yes No If yes, how many years? __________ Currently? Yes No
How many packs per day? __________

ALCOHOL USE

How much alcohol do you drink each week?
Wine: _____ glasses per week Beer: _____ bottles/cans per week Liquor: ______drinks per week
Have you ever had an issue with heavy drinking? Yes No

DRUG USE

Do you use any recreational drugs (marijuana, cocaine, etc.)? Yes No
If yes, which ones? ____

EMPLOYMENT

Current or past occupation: ____
Current work status: Actively working Work at Home Retired Care-taking Disabled Unemployed

SOCIAL HISTORY

Who do you live with? ____

Relationship status: Single Married Partnered Widowed Separated Divorced

If married or partnered, how many years have you been in the relationship? __________

Do you have children? __________ If so, how many? __________

FAMILY HISTORY

Do you have a family history of any of the following conditions?

❒ Arthritis
❒ Heart Attack
❒ Heart Disease
❒ Peripheral Vascular Disease
❒ Hypertension
❒ High Cholesterol
❒ Diabetes Mellitus
❒ Stroke
❒ Cancer