

GEORGIA BRAIN AND SPINE CENTER
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www.georgiabrainandspine.com

PATIENT MEDICAL HISTORY

****All of the information requested is extremely important. We need complete and concise answers to****
ALL of the questions in order to provide you with the safest and very best medical care.

PERSONAL INFORMATION

Date: _____

Patient Name _____

Last

First

Middle

Address _____

Street

City

State

Zip Code

Home Phone: (_____) _____ Cell Phone: (_____) _____

Date of Birth: ____/____/____ Gender: M or F Age: ____ SSN# _____

Occupation: _____ Employer _____ Work Phone # _____

Emergency Contact and Phone #: _____

Family Physician/Internist _____ Phone #(_____) _____

Referring Physician _____ Phone #(_____) _____

Other Referral _____ Phone # (_____) _____

INSURANCE INFORMATION

Primary Insurance _____ ID# _____ Group# _____

Address _____

Insured Name _____ Relationship to Insured _____

Secondary Insurance _____ ID# _____

Address _____

Group # _____ Insured Name _____ Relationship _____

Auto/Workers Comp Insurance _____ Claim# _____

Address _____

Date of Injury/Accident _____ Type of Injury Auto Workers Compensation

Adjusters Name _____ Phone # (_____) _____

MEDICAL INFORMATION

Patient Name: _____

Reason for your visit today? _____

How long have you had this problem? _____

Were you injured in an accident? Yes No If yes check one: Motor Vehicle Accident
 Worker's Comp Accident other _____

Have you had any other prior injuries? Yes No If yes, please list: _____

MEDICAL INFORMATION CON'T:

Have you had same or similar symptoms in the past? Yes No If yes, please describe:

Have you had any of the following treatment(s) for your current symptoms?

	<u>No</u>	<u>Yes</u>	<u>Length of Treatment</u>	<u>Treatment Provider</u>
Traction	—	—	_____	_____
Chiropractic Manipulation	—	—	_____	_____
Physical Therapy	—	—	_____	_____
Massage	—	—	_____	_____
Exercise Therapy	—	—	_____	_____
Trigger Point Injections	—	—	_____	_____
Acupuncture	—	—	_____	_____
Epidural Steroid Injections	—	—	_____	_____

Height _____ Weight _____ Are you Claustrophobic? Yes No

PAST MEDICAL HISTORY:

Any metal in your body? (Pacemaker, aneurysm clips, rods, screws, pins shrapnel etc.) Yes No

If yes, explain: _____

Have you ever been treated for:

	<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>
Anemia	—	—	Bleeding Disorder	—	—
High Blood Pressure	—	—	Heart Attack	—	—
Ulcer	—	—	HIV/AIDS	—	—
Cancer	—	—	Asthma and/or Emphysema	—	—
MRSA	—	—	Liver Problems	—	—
Epilepsy	—	—	Kidney Problems	—	—
Stroke	—	—	Heart Disease/Angina	—	—
Diabetes	—	—	Alcohol or Drug Abuse	—	—

Please list any other serious medical conditions not on the above list: _____

Patient Name: _____

ALLERGIES: Please list any medication or other allergies that you might have.

Latex Allergy: _____ YES _____ NO

PREVIOUS SURGERY: Please list **ALL** operations you have had.

Type of surgery	Month/Year	Surgeon	City
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT MEDICATIONS: Please take the time to completely and accurately list **ALL** of the medications you currently take, including aspirin, vitamins and other supplements. (You may attach a medication list.)

Name of medication	Dosage	How often	Taken for:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY: Please list any serious illnesses that have occurred in your family.

Cancer Yes [] No [] Relation _____

Heart Disease Yes [] No [] Relation _____

Stroke Yes [] No [] Relation _____

Diabetes Yes [] No [] Relation _____

Aneurysm Yes [] No [] Relation _____

Brain Tumor Yes [] No [] Relation _____

Other Neurological or Muscular Diseases
Yes [] No [] Relation _____

Other serious illnesses
Yes [] No [] Relation _____

SOCIAL HISTORY:

Patient Name: _____

Married? Yes [] No [] Spouse's name and phone # _____

Is there a family member or friend living with or near you who would be available to assist you once you've been discharged from the hospital, should the need arise? Yes [] No []

Name/Phone _____

Do you smoke? Yes [] No [] How many packs per day? _____

If yes, how old were you when you started? _____ How old were you when you stopped? _____

Do you drink alcohol? Yes [] No [] If yes, in an average week, how many drinks do you consume? _____

Do you use any recreational or illegal drugs? Yes [] No [] If yes, please specify: _____

Patients Name _____

D.O.B _____

REVIEW OF SYSTEMS:

Do you currently, or have you had problems with:

Constitutional

- Fever..... Yes No
- Weight Loss..... Yes No
- Excess Fatigue..... Yes No
- Night Sweats..... Yes No

Eyes

- Wear Glasses..... Yes No
- Date of last exam: _____
- Infections..... Yes No
- Injuries..... Yes No
- Glaucoma..... Yes No
- Cataracts..... Yes No

Ear, Nose, Throat and Mouth

- Wear hearing aids..... Yes No
- Date of last exam: _____
- Hearing Loss..... Yes No
- Ear Infections..... Yes No
- Ringing in Ears..... Yes No
- Left Right Both
- Balance Disturbance..... Yes No
(i.e. Vertigo, spinning)
- Nosebleeds..... Yes No
- Nasal Congestion..... Yes No
- Nasal Drainage..... Yes No
- Inability to smell..... Yes No
- Sinus Problems..... Yes No
- Sore Throats..... Yes No
- Mouth Sores..... Yes No

Cardiovascular

- Chest Pain or Angina..... Yes No
- Date of last EKG: _____
- High Blood Pressure..... Yes No
- Irregular Pulse..... Yes No
- Heart Murmur..... Yes No
- High Cholesterol..... Yes No
- Swelling of feet/hands..... Yes No
- Leg pain while walking... Yes No

Respiratory

- Asthma..... Yes No
- Chronic Cough..... Yes No
- Emphysema..... Yes No
- Shortness of breath..... Yes No
- Bronchitis..... Yes No
- Pneumonia..... Yes No
- Lung Cancer..... Yes No
- Bloody Sputum..... Yes No
- Date of last chest x-ray: _____

(Circle yes or no)

Gastrointestinal

- Indigestion or Pain with eating..... Yes No
- Nausea..... Yes No
- Blood in your vomit..... Yes No
- Liver Disease..... Yes No
- Jaundice..... Yes No
- Abdominal Pain..... Yes No
- Change in Bowel Habits..... Yes No
- Ulcer or Gastritis..... Yes No

Genitourinary

- Urinary Tract Infections..... Yes No
- Painful urination..... Yes No
- Blood in your urine..... Yes No
- Incontinence..... Yes No
- Kidney Stones..... Yes No
- Prostate Cancer (Males)..... Yes No
- Endometriosis (Females)..... Yes No
- Uterine or Cervical Cancer..... Yes No

Musculoskeletal

- Broken bones..... Yes No
- List: _____
- Neck pain..... Yes No
- Arm pain Yes No
- Arm weakness Yes No
- Leg pain Yes No
- Leg weakness..... Yes No
- Back pain..... Yes No
- Joint pain or swelling..... Yes No
- Arm numbness/tingling..... Yes No
- Leg numbness/tingling..... Yes No

Integumentary

- Skin Disease..... Yes No
- Skin Cancer..... Yes No
- Breast pain, tenderness or swelling
(Females)..... Yes No
- Nipple discharge (Females)..... Yes No
- Date and result of last Mammogram:
(Females) _____

Neurological

- Fainting spells or "Blacking Out"..... Yes No
- Seizures..... Yes No
- Memory Problems..... Yes No
- Disorientation..... Yes No
- Difficulty with speech..... Yes No
- Headache..... Yes No
- Double or blurred vision..... Yes No
- Face weakness..... Yes No
- Coordination in arms..... Yes No
- Coordination in legs..... Yes No

Patients Name: _____

D.O.B: _____

REVIEW OF SYSTEMS CON'T:

Psychiatric

Anxiety.....Yes No
Depression.....Yes No
Other Psychiatric disorder/treatment. Yes No
If yes, please explain: _____

Endocrine

Diabetes.....Yes No
Thyroid Disease.....Yes No
Increased appetite.....Yes No
Excessive thirst or urination.....Yes No
Hormone Problems.....Yes No

Hematologic/Lymphatic

Anemia.....Yes No
Hemophilia.....Yes No
Bleeding Tendencies.....Yes No
Persistent Swollen Glands
or Lymph Nodes.....Yes No
Blood Transfusion.....Yes No
If yes, when? _____

Allergic/Immunologic

Food Allergies.....Yes No
Inhalant (nasal) Allergies.....Yes No
Immunologic Disorders.....Yes No

**The above information is accurate to the best I
have reviewed the above of my knowledge.**

Patient Signature

Date

**I have reviewed the above information with the
patient.**

Physician Signature

Date