SEMMES MURPHEY
Leaders in Brain & Spine Care

Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____

MEDICAL HISTORY

CHIEF COMPLAINT (Describe your problem and what treatment you have had): _____

_____

_____

_____

What doctors have you seen for this problem, and what tests have you had? _____

_____

PAST MEDICAL HISTORY (Have you ever been diagnosed with the following?)

Autoimmune
__ Arthritis (Rheumatoid)
__ Lupus

Blood Disorder
__ Anemia
__ Factor VIII
__ Hemophilia
__ Sickle Cell Disease
__ Von Willebrand Disease

Cardiovascular
__ Abdominal Aneurysm
__ Aortic Aneurysm
__ Atrial Fibrillation
__ Blood Vessel Blockage
__ Carotid Artery Disease
__ Coronary Artery Disease
__ Heart Attack
__ Heart Failure
__ High Blood Pressure
__ High Cholesterol
__ Peripheral Vascular Disease
__ Pulmonary Embolism

Nervous System
__ ADD/ADHD
__ Brain Aneurysm
__ Migraines
__ Multiple Sclerosis
__ Neuropathy
__ Parkinson's Disease
__ Seizure Disorder
__ Stroke

Endocrine
__ Diabetes- Type1
__ Diabetes- Type 2
__ Hyperthyroidism
__ Hypothyroidism

Infectious Disease
__ HIV
__ MRSA
__ Tuberculosis

Musculoskeletal
__ Osteoarthritis
__ Osteoporosis
__ Scoliosis

Psychiatric
__ Alcoholism
__ Anxiety
__ Depression

Genitourinary
__ Chronic Renal Insufficiency
__ Dialysis
__ Enlarged Prostate
__ Kidney Disease
__ Kidney Stones
__ Recurrent Urinary Tract Infections
__ Urinary Difficulty

Other: _____
_____
_____
_____

Pulmonary
__ Asthma
__ COPD
__ Emphysema
__ Sleep Apnea
__ Snoring

Gastrointestinal
__ Cirrhosis
__ Diverticulitis
__ Gastric Reflux
__ GI Bleed
__ Hepatitis (Type:_____)
__ Peptic Ulcer Disease

Do you have a history of cancer? ____ No ____ Yes. IF YES, what type? _____

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SURGICAL HISTORY List ALL previous surgeries including date

_____

_____

Use the back of this sheet if you need more space

Have you ever had any problems with anesthesia? ___ Yes ___ No If YES, what kind? _____
Do you have a family history of malignant hyperthermia? ___ Yes ___ No
Do you have a history of surgical complications? ___ Yes ___ No If YES, explain: _____
Do you have any implantable devices? ___ Yes ___ No If YES, what kind? _____

SOCIAL HISTORY

Do you use tobacco products (cigarettes/pipe/chewing tobacco/cigars/E-cigarettes)? Type: _____
Current____ How much? _____ Former____Quit, When? _____ Never____ Unknown ____
Do you use alcohol regularly? _____ If so, how much? _____
Any recreational drug use? ___ Yes ___ No
Regular Exercise? ___ Yes ___ No
Do you have any religious beliefs that would affect your care? ___ Yes ___ No
What is your occupation? _____
Are you: _____ Right handed _____ Left handed _____ Ambidextrous
Are you: _____ Single _____ Married _____ Widowed _____ Divorced
Have you traveled outside the U.S. in the last year? When? Where? _____

FAMILY HISTORY List ONLY these family members: Father(F)/ Mother(M)/ Brother(B)/ Sister(S)

Alzheimer's _____
Alcoholism _____
Aneurysm _____
Blood Disorder _____
Cancer (Type?)_____ _____
COPD _____
Diabetes _____
Seizures _____
Stroke _____
Liver Disease _____
Migraines _____
Heart Disease _____
Spine Surgery _____
Hypertension _____
Thyroid Disease_____
Hereditary Disorder_____
Other_____ ____

DRUG ALLERGIES & REACTIONS (If allergic, list your reaction beside the drug name)

Codeine _____
Demerol _____
Iodine _____
Latex _____
Morphine _____
Penicillin _____
Sulfa _____
Tetanus _____
Xylocaine_____
Food _____
Tape _____
Other _____

MEDICATIONS AND VITAMINS (Including over the counter medications)

Name	Strength	How Often?

Use the back of this sheet if you need more space

Pharmacy Name: _____ Pharmacy Phone #: _____

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REVIEW OF SYSTEMS (Do you currently have or have you experienced any of the following within the past year?)

General
___Fever
___Chills
___Sweats
___Weight Loss
___Weight Gain
___Sleep Disturbance
___Feeling Run Down

Eyes
___Blurry Vision
___Blindness
___Eye Pain
___Eye Discharge
___Sensitivity to Light

ENT
___Hearing Loss
___Earache
___Ear Discharge
___Ringing in Ears
___Nosebleeds
___Sore Throat
___Hoarseness
___Trouble Swallowing

Cardiovascular
___Chest Pain
___Palpitations
___Fainting
___Ankle Swelling
___Breathing Difficulty

Respiratory
___Cough
___Wheezing
___Coughing up Blood
___Shortness of Breath
___Sleep Apnea

Gastrointestinal
___Constipation
___Indigestion
___Nausea/Vomiting
___Diarrhea
___Change in Bowel Habits
___Abdominal Pain
___Dark Tarry Stool
___Bleeding from Rectum
___Jaundice
___Reflux/GERD

Genitourinary
___Urinary Frequency
___Bladder Control
___Painful Urination
___Pelvic Pain
___Sexual Dysfunction
___Impotence
___Abnormal Menstrual Period

Musculoskeletal
___Joint Pain
___Joint Swelling
___Arthritis
___Muscle Pain
___Muscle Weakness
___Stiffness

Neurologic
___Stroke
___Numbness
___Paralysis
___Seizures
___Migraines
___Tremors
___Memory Loss

Psychiatric
___Depression
___Anxiety
___Suicidal Thoughts
___Mental Disturbance
___Hallucinations
___Paranoia

Endocrine
___Cold Intolerance
___Heat Intolerance
___Excessive Thirst
___Excessive Urination
___Diabetes
___Thyroid Dysfunction

Skin
___Rash
___Itching
___Dryness
___Suspicious Lesions

Hematologic/Lymph
___Abnormal Bruising
___Abnormal Bleeding
___Enlarged Lymph Nodes

Allergic/Immunologic
___Rashes
___Hay Fever
___Persistent Infections
___HIV Exposure

Other:_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Patient Signature Date