

Blue Ridge Neuroscience Center, P.C.
2 Sheridan Square, Suite 200
Kingsport, TN 37660
MEDICAL HISTORY QUESTIONNAIRE
Please Print Neatly Only in Black or Blue Ink

Name: _____
 Phone: _____

Date: _____
 Cell: _____

Address: _____

Birth Date: ____/____/____ Age: _____ Social Security No: ____-____-____

What is your chief complaint today? _____
 Have you seen any specialists for this problem? _____
 If so who have you seen? _____

It is very important that you completely fill out the questionnaires we have sent you regarding your past medical history, past surgical history, present illnesses and treatments, and other information. This information is the primary database from which we work to help us in deciding your best course of treatment. Failure to provide complete and/or accurate information will adversely impact our ability to provide you with appropriate care and may cause you harm, debility, or death.

Current Medications (please bring all medications with you to every visit, not a list)

MEDICATION NAME	DOSAGE	MEDICATION NAME	DOSAGE

Pharmacy Name: _____ Pharmacy Telephone: _____

ALLERGIES

ALLERGY	SIDE EFFECT(S)	ALLERGY	SIDE EFFECT(S)

Are you allergic to Latex? Yes No

PAST MEDICAL HISTORY (Please check all that apply to you)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> High blood pressure
Do you control this with :
Medication? | <input type="checkbox"/> High Cholesterol
Do you control this with: Diet?
Medication? | <input type="checkbox"/> Cancer
What type?
When? | <input type="checkbox"/> Hepatitis
What type?
What year?
As a child? |
| <input type="checkbox"/> Heart Attack
If so, when? | <input type="checkbox"/> Diabetes
Type I? Type II? | <input type="checkbox"/> Lung Disease
What type? | <input type="checkbox"/> AIDS/HIV
If so, when? |
| <input type="checkbox"/> Angina
Do you control this with:
Medication? | <input type="checkbox"/> Stroke
If so, when? | <input type="checkbox"/> Thyroid Disease
Do you control this with:
Medication? | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Irregular Heart Beat
Do you control this with:
Medication? | <input type="checkbox"/> Seizure
Do you control these with:
Medication? | <input type="checkbox"/> Ulcers
Peptic? Bleeding?
Active? | <input type="checkbox"/> Other_____ |

Do you drink alcohol? Yes No What do you drink? Beer Wine Liquor
 How much and how often? Amount: _____ rarely occasionally frequently daily
 How long have you been drinking? _____ #Years Ever treated for alcohol abuse? Yes No
 Do you use any other type of tobacco or drugs? Yes No If yes, what?

OCCUPATIONAL HISTORY

Employer/Occupation: _____ Are you currently working? Yes No
 What is your work status now? retired (date _____) fired part time laid off full time light duty
 Have you missed work due to your current symptoms? Yes No If yes, how much? _____
 Date last worked: _____ Nature of Illness? injury work-related injury accident MVA illness
 (if injured) Date of injury: _____ Sate (e.g. TN, VA, KY, NY) where injury occurred: _____

THERAPY HISTORY

Have you had physical therapy? _____ Where: _____ When: _____
 Do you engage in a routine exercise program? _____ If so, what type? _____
 Epidural steroid injections Corticosteroid injections
 Please check if you have had any of the following: Trigger point injections Steroid injections
 Other: _____

REVIEW OF SYMPTOMS

(Please check all that apply during this illness)

- | | | | |
|--|--|--|---|
| Skin:
<input type="checkbox"/> abnormal hair loss/growth
<input type="checkbox"/> bleeding disorders
<input type="checkbox"/> bruising easily
<input type="checkbox"/> rash
<input type="checkbox"/> scars
<input type="checkbox"/> tattoos | Chest:
<input type="checkbox"/> chest pain (lungs)
<input type="checkbox"/> chronic cough
<input type="checkbox"/> coughing blood
<input type="checkbox"/> pneumonia
<input type="checkbox"/> shortness of breath | GI:
<input type="checkbox"/> abdominal pain
<input type="checkbox"/> blood in stool
<input type="checkbox"/> nausea
<input type="checkbox"/> ulcers (bleeding?)
<input type="checkbox"/> vomiting
<input type="checkbox"/> vomiting blood | Musculoskeletal:
<input type="checkbox"/> arm pain
<input type="checkbox"/> arthritis
<input type="checkbox"/> back pain
<input type="checkbox"/> joint pain
<input type="checkbox"/> leg pain
<input type="checkbox"/> missing finger(s)
<input type="checkbox"/> missing toe(s) |
| Head/Eyes/Ears/Nose/Throat
<input type="checkbox"/> visual loss (glasses)
<input type="checkbox"/> blurred vision
<input type="checkbox"/> double vision
<input type="checkbox"/> eye pain
<input type="checkbox"/> hearing loss
<input type="checkbox"/> bleeding gums
<input type="checkbox"/> sore tongue
<input type="checkbox"/> sore throat | Heart:
<input type="checkbox"/> chest pain (angina)
<input type="checkbox"/> difficulty breathing
<input type="checkbox"/> heart murmur
<input type="checkbox"/> leg weakness
<input type="checkbox"/> MI
<input type="checkbox"/> swelling of legs | GU:
<input type="checkbox"/> blood in urine
<input type="checkbox"/> frequency/urgency
<input type="checkbox"/> incontinence
<input type="checkbox"/> kidney stones
<input type="checkbox"/> UTI's | Neurological:
<input type="checkbox"/> blurred vision
<input type="checkbox"/> double vision
<input type="checkbox"/> dizziness
<input type="checkbox"/> headaches
<input type="checkbox"/> migraines
<input type="checkbox"/> numbness/tingling
<input type="checkbox"/> paralysis
<input type="checkbox"/> seizures
<input type="checkbox"/> stroke |
| Psychiatric:
<input type="checkbox"/> anxiety
<input type="checkbox"/> depression
<input type="checkbox"/> sleep disturbance (Is this due to your current symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No)
<input type="checkbox"/> other psychiatric disorder, please describe: _____ | | | |