

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

Name: \_\_\_\_\_

**SURGICAL HISTORY**

Type of Surgery	Surgeon Name	Facility	Date

**FAMILY HISTORY**

Is your mother  living or  deceased? Age: \_\_\_\_\_ Cause of death: \_\_\_\_\_  
If living, please describe her health: \_\_\_\_\_ Is she in: Good? Fair? Poor? Health \_\_\_\_\_

Is your father  living or  deceased? Age: \_\_\_\_\_ Cause of death: \_\_\_\_\_  
If living, please describe his health: \_\_\_\_\_ Is he in: Good? Fair? Poor? Health \_\_\_\_\_

**Please check all that apply to your family  
Circle F for father's side and M for mother's side.**

- High blood pressure      F   M   Family Member(s): \_\_\_\_\_
- Heart Disease              F   M   Family Member(s): \_\_\_\_\_
- Stroke(s)                      F   M   Family Member(s): \_\_\_\_\_
- Seizures                        F   M   Family Member(s): \_\_\_\_\_
- Diabetes                        F   M   Family Member(s): \_\_\_\_\_
- Migraines                      F   M   Family Member(s): \_\_\_\_\_
- Cerebral Aneurysm(s)      F   M   Family Member(s): \_\_\_\_\_
- Cancer \_\_\_\_\_  
Type                              F   M   Family Member(s): \_\_\_\_\_
- \_\_\_\_\_                              F   M   Family Member(s): \_\_\_\_\_  
Type

**SOCIAL HISTORY**

Level of Education:  Elementary Grade?     High School Grade complete?     College/Years

Are you  right-handed     left-handed     both?

How many children?    Living: # \_\_\_\_\_    Deceased: # \_\_\_\_\_

Do you smoke?  Yes     No    If yes, how long?    Years: # \_\_\_\_\_  
(Circle packs per day)  
0   1/2   1   1 1/2   2   2 1/2   3   \_\_\_\_\_

Do you have a history of smoking?    When did you    Year:  
quit?    quit?

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)*

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