NeuroSpine Institute

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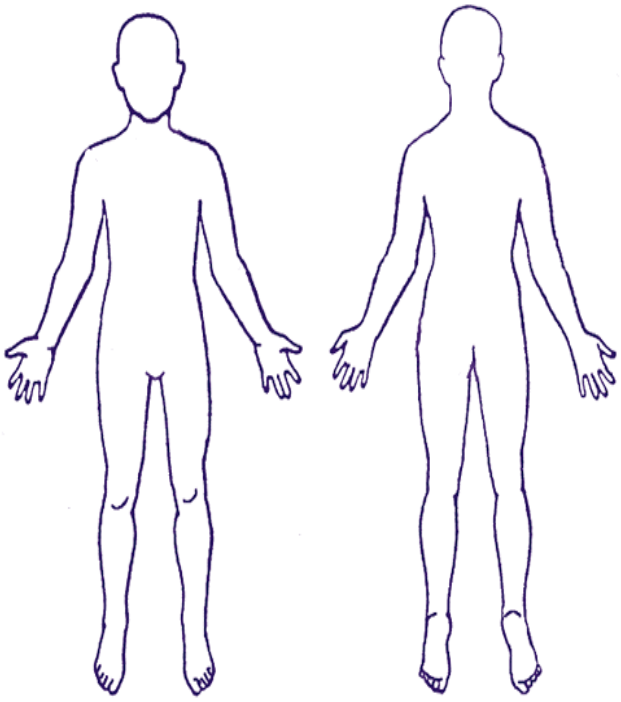
Name: _____ DOB: _____ Age: _____ Sex: _____
Occupation _____

Referring Doctor: _____ Family Doctor: _____

Have you seen Dr. Angeles in the past? Yes No If yes, when? _____
Reason for today's visit:_____

Describe your symptoms. Please fill out and use the diagram below to assist you in your description. _____
_____
_____

Front Back



Mark these drawings according to where you hurt. If the back of your neck hurts, mark the back of the neck, etc… If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram.

Numbness: z
Burning: x
Ache: a
Stabbing: /
Pins & Needles: o

How long have you had the above symptoms? _____

Other doctors you have seen for this condition: _____
_____

What kind of treatment did they recommend? _____
_____

Is this the result of a specific injury or accident? Yes No
Are you involved in litigation regarding this condition? Yes No

Date of accident_____ Type of accident _____

Allergies	Reaction	Comments

Are you allergic to IV contrast or shell fish? Yes No

Medications:

Name	Dose	How often taken?

Medical History (circle 'yes' or 'no')

Atrial Fibrillation **yes no**	Hepatitis C **yes no**	Parkinson's disease **yes no**
Aortic Stenosis **yes no**	Stomach ulcers **yes no**	Stroke **yes no**
Heart Disease **yes no**	Anemia **yes no**	Nerve/muscle disease **yes no**
	Deep vein thrombosis **yes no**	
High Cholesterol **yes no**	Leukemia **yes no**	Alcohol Problem **yes no**
High Blood Pressure **yes no**	Pulmonary embolism **yes no**	Depression **yes no**
Myocardial infarction **yes no**	Infection w/ MRSA **yes no** (methacillin resistant staph)	Asthma **yes no**
Blood clotting disorder **yes no**	Infection with VRE **yes no**	Emphysema (COPD) **yes no**
Heart Murmur **yes no**	Dementia **yes no**	Obstructive sleep apnea **yes no**
Artificial heart valve **yes no**	Seizure Disorder **yes no**	Tuberculosis **yes no**
Blood vessel blockage **yes no** (arm or leg)	Brain tumor **yes no**	Endstage renal disease **yes no** (kidney failure)
Diabetes **yes no**	Other:	Urinary insufficiency **yes no**
Thyroid Disease **yes no**		Obesity **yes no**
Cancer **yes no**		Drug abuse **yes no**
Immune disorder **yes no**		

Past Surgical History:_____

_____

_____

Family Health History _____

_____

_____

Social History:

Tobacco Use
Yes No Quit _____ (quit date)
Packs/day _____
For how many years? _____

Alcohol Use
Yes No
# of Drinks/Week _____ Can(s) of beer each week
_____ Shot(s) of liquor each week
_____ Drink(s) containing 0.5 oz of alcohol each week

Exercise
Yes No
If yes, how much? □ Rarely □ Occasionally □ >3 times/week

Educational Background
What is your highest education level?
□ Highschool □ Vocational degree □ College □ Advanced Degree □ Other:

Current Occupation: _____
Present Employment Status: □ Fulltime □ Part-time □ Retired □ Disability □ Other:
If not working, what was your last job? _____
If not working, how long have you been out of work? _____

Marital Status: □ Single □ Married □ Divorced □ Widowed
Do you have children? □ Yes □ No If yes, how many? ____ What are their ages? _____

Where do you live? _____
Who do you live with? _____

What daily activities do you enjoy? _____
_____
_____

Do you presently have any problems or symptoms in the following areas?

□ Environmental allergies	□ Chest Pain	□ Irregular heart rhythm
□ Recurrent fevers, chills, sweats	□ Recent weight changes	□ Extreme fatigue
□ Chronic sinus problems	□ Voice changes	□ Changes in vision
□ Heat or cold intolerance	□ Excess thirst or urination	□ Severe heart burn
□ Vomiting blood	□ Frequent diarrhea	□ Constipation
□ Abdominal Pain	□ Burning with urination	□ Lack of bladder control
□ Change in sexual function	□ Easy Bruising	□ Frequent bleeding
□ Enlarged lymph nodes	□ Difficulty walking	□ Headaches
□ Numbness/tingling sensation	□ Weakness	□ Seizures
□ Loss of Vision	□ Nervousness	□ Depression
□ Shortness of Breath	□ Coughing up blood	□ Chronic cough

I attest that all information I provided is true and correct to the best of my knowledge.

Patient's signature: _____ Date: _____

Physician's signature: _____ Date: _____