



801 W 5th Ave Ste 210, Spokane, WA. 99204
www.spokanebrainandspine.com

Date: ___/___/___

Date of Birth: ___/___/___

Last Name First MI

Address

Home Phone Cell Phone Work Phone

Referring Doctor (First and Last name) Primary Care Provider

Reason for visit? _____

How long has it been present? _____

Operations/Hospitalizations (use back of form if needed)

- 1. _____ -Date _____
- 2. _____ -Date _____
- 3. _____ -Date _____
- 4. _____ -Date _____
- 5. _____ -Date _____

Illnesses/diseases/injuries/accidents

Please list all medications and dosage – including over the counter meds

Allergies to medications

Do you use tobacco? Yes _____ No _____
 Smoke ___ Pipe ___ Cigars ___ Chew ___
 How much? _____ for how long? _____
 Do you drink alcohol? Yes _____ No _____
 If yes, how much? _____

What is your occupation? _____
 Are you currently working? Yes ___ No ___ if No, why not _____

If not currently working because of injury, date you stopped. _____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___
 Do you have children Yes ___ No ___ if yes, how is their health? _____

Family Member	Alive	Deceased	Age	Health status/cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Are you currently, or have you had problems with

Constitutional: Circle one

Fever Yes No
 Weight Loss Yes No

Eyes:

Wear Glasses Yes No
Glaucoma Yes No
Cataracts Yes No
 Double Vision Yes No

Ear, Nose, Throat and Mouth

Wear Hearing Aids Yes No
 Ear Infections Yes No
 Hearing Loss Yes No
 Ringing in Ears - Left Right Both Yes No
 Nasal Congestion Yes No
 Sinus Headache Yes No
 Sore Throats Yes No
 Swallowing Problems Yes No
 Mouth Sores Yes No

Cardiovascular

Chest Pain or Angina Yes No
 If yes, Date of last eval. _____

High Blood Pressure

Irregular Pulse Yes No
 Fainting Spells – Blacking out Yes No

Cardiovascular cont.

Heart Murmur Yes No
High Cholesterol Yes No
 Swelling in feet or 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

Gastrointestinal

Indigestion or Pain with Eating Yes No
 Nausea Yes No
 Vomiting Yes No
Liver Disease Yes No

Jaundice Yes No
 Abdominal Pain Yes No
 Change in Bowel Habits Yes No
Ulcers or Gastritis Yes No
Colon Cancer Yes No

Genitourinary **Circle one**
 Urinary Tract Infections Yes No
 Painful Urination Yes No
 Blood in Urine Yes No
 Incontinence Yes No
Kidney Stones Yes No
Prostate Cancer Yes No
Endometriosis Yes No
Uterine or Cervical Cancer Yes No

Musculoskeletal
 Broken Bones Yes No
 List _____

Arm Weakness Yes No
 Leg Weakness Yes No
 Back Pain Yes No
 Arm Pain Yes No
 Leg Pain Yes No
 Joint Pain Yes No
 Joint Swelling Yes No
Arthritis Yes No

Integumentary
Skin Disease Yes No

Skin Cancer Yes No
Endocrine **Circle one**
Diabetes Yes No
Thyroid Disease Yes No

Hematologic/Lymphatic
 Anemia Yes No
Hemophilia Yes No
 Bleeding Tendencies Yes No
 Swollen Glands/Lymph Nodes Yes No
 Blood Transfusion Yes No

If yes, when _____

Neurological
 Balance Problem (vertigo, Spinning) Yes No
Seizures Yes No
Stroke Yes No
 Disorientation Yes No
 Difficulty with your Speech Yes No
 Inability to Concentrate Yes No
 Face Weakness Yes No
 Poor Coordination of Arm or Legs Yes No
 Numbness Yes No

Where _____

Psychiatric
Anxiety Yes No
Depression Yes No
Other Psychiatric Disorder/Treatment

Height _____ Weight _____

Please mark the severity of your pain today on the following line

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
 No pain Worst pain ever

The above information is accurate to the best of my knowledge.

 Patient Signature Date

I have reviewed the above information with the patient

 Signature Date