Cooper Neurological Institute

Phone: 856-968-7965 Fax: 856-968-8697

PATIENT INFORMATION AND HEALTH HISTORY

Name: _____ Date: _____
Birth date: _____ Age: _____
Home Phone: _____ Cell Phone: _____

If patient is a minor or disabled, please provide name of parent or legal guardian and phone number
_____

Emergency Contact:
Name _____ Phone _____
Primary Care physician: _____
Address: _____
Phone: _____ Fax: _____
Referring physician: _____
Address: _____
Phone: _____ Fax: _____

Please list any other physician or specialist that is treating you (i.e. Cardiologist, Endocrinologist, Neurologist, Pain Mgt)
Name Address and Phone
_____
_____
_____
_____

Height: _____ Weight: _____
Right-handed _____ Left-handed _____ Ambidextrous _____

Are you involved in any litigation with regards to your health? ☐ No ☐ Yes If yes, please provide details and your attorney's name and phone number:
_____
_____

MAJOR COMPLAINT AND HISTORY OF PRESENT ILLNESS

WHAT IS YOUR MAJOR COMPLAINT? (Explain why you are here, including symptoms, body part, etc.)_____
_____
_____

IS THIS AN INJURY? ☐ No ☐ Yes **IF YES, DATE INJURY OCCURRED**: _____
IS THIS WORK RELATED? ☐ No ☐ Yes
IS THIS RELATED TO A MOTOR VEHICLE ACCIDENT? ☐ No ☐ Yes
HOW LONG HAVE YOU HAD THIS PROBLEM? _____
DESCRIBE IN DETAIL WHAT HAPPENED:
_____
_____
_____

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DESCRIBE YOUR PAIN: (dull, sharp, constant, stabbing, numb, tingling, electric-like, ache, other)

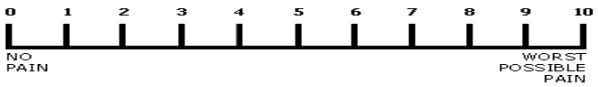
_____

_____

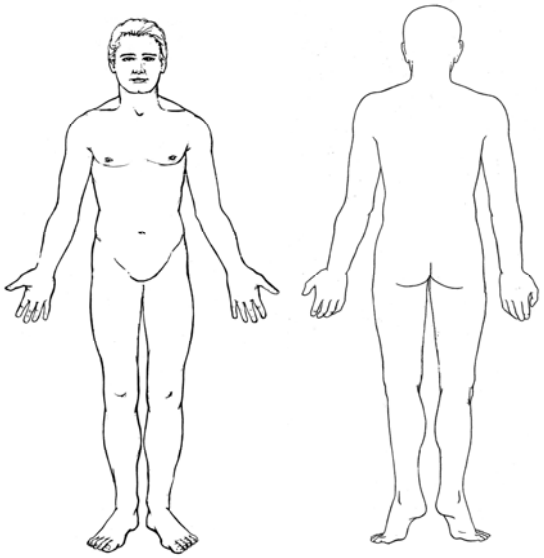
_____

_____

USE PAIN SCALE TO RATE PAIN:



USE FIGURES BELOW TO SHOW WHERE YOUR PAIN IS:



WHAT TRIGGERS THE PAIN? _____

WHAT TIME OF DAY DOES THE PAIN START? _____

WHAT MAKES IT BETTER? _____

WHAT MAKES IT WORSE? _____

HAS THIS AREA EVER BEEN INJURED BEFORE? ☐ No ☐ Yes

IF YES, WHO TREATED YOU AND WHEN? _____

HAVE YOU HAD SURGERY TO THIS AREA? ☐ No ☐ Yes

IF YES, WHEN AND BY WHAT SURGEON? _____

HAVE YOU HAD:	TYPE, WHERE AND WHEN:	DID THIS HELP?
☐ X-RAYS	_____	
☐ MRI	_____	
☐ CAT SCAN	_____	
☐ ULTRASOUND	_____	
☐ OTHER	_____	
HAVE YOU HAD:		**DID THIS HELP?**
☐ PHYSICAL THERAPY	_____	☐ Yes ☐ No
☐ OCCUPATIONAL THERAPY	_____	☐ Yes ☐ No
☐ MEDICATIONS	_____	☐ Yes ☐ No
☐ INJECTIONS	_____	☐ Yes ☐ No
☐ BRACES	_____	☐ Yes ☐ No
☐ ORTHOTICS or SPECIAL SHOES	_____	☐ Yes ☐ No

Past Medical History **Please note any illness or medical condition that you have had IN THE PAST:**

	COMMENTS		COMMENTS
___ anemia	_____	__ heart rhythm abnormality	_____
___ aneurysm	_____	__ hepatitis type:	_____
___ arthritis	_____	__ high blood pressure	_____
___ asthma	_____	__ high cholesterol	_____
___ bleeding (brain)	_____	__ hyperthyroid (high)	_____
___ blood clot	_____	__ hypothyroid (low)	_____
___ brain/spine/nerve injury	_____	__ kidney disease	_____
___ bronchitis	_____	__ migraines	_____
___ cancer type:	_____	__ osteoarthritis	_____
treatment:	_____	__ osteoporosis	_____
type:	_____	__ Parkinson's disease	_____
treatment:	_____	__ pituitary tumor	_____
___ concussion	_____	__ pneumonia	_____
___ COPD/emphysema	_____	__ scoliosis	_____
___ degenerative disc disease	_____	__ seizures	_____
___ diabetes	_____	__ sleep apnea	_____
___ dystonia	_____	__ stroke	_____
___ fibromyalgia	_____	__ TIA	_____
___ gall bladder problems	_____	__ tuberculosis	_____
___ GERD	_____	__ ulcers	_____
___ heart attack	_____	__ valve disorder (heart)	_____
___ heart failure/CHF	_____	__ Other	_____
___ heart murmur	_____		

Past Surgical History **Please list all previous surgeries you have had:**

Type of Surgery	Year or Age
_____	
_____	
_____	
_____	
_____	
_____	

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Please list all current medications, vitamins, herbs or over the counter medications that you are taking:

Medication	Dose	Frequency	When did you start the medication?	Prescribing Doctor
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Do you have any allergies to any medications? ☐ No ☐ Yes If yes, please list below

Medication	Type of Reaction

Do you have an allergy to latex? ☐No ☐ Yes Type of Reaction: _____
Do you have an allergy to tape? ☐No ☐Yes Type of Reaction: _____
Do you have an allergy to iodine or contrast dye? ☐ No ☐Yes Type of Reaction: _____
Do you have an allergy to any foods? ☐No ☐Yes List: _____
Do you have seasonal or environmental allergies? ☐ No ☐Yes List:_____

Social, Smoking and Drug History

Do you smoke presently? ☐ No ☐ Yes If yes, what do you smoke? _____
How much do you smoke? _____
Are you an ex-smoker? ☐ No ☐ Yes If yes, when did you stop? _____
How much did you used to smoke? _____
Do you drink alcohol? ☐ No ☐ Yes If yes, what do you drink?_____
How much do you drink? _____
Are you an ex-drinker? ☐ No ☐ Yes If yes, when did you stop? _____
Do you use recreational or illegal drugs? ☐ No ☐ Yes If yes, please list _____
Do you drink caffeinated beverages? ☐ No ☐ Yes If yes, how many per day? _____
Do you wear glasses or contacts? ☐ No ☐ Yes
Do you wear dentures? ☐ No ☐ Yes If yes: ☐ uppers ☐ lowers

What is your occupation? _____
Are you currently working? ☐ Yes ☐ No If no, when did you stop? _____
With whom do you live? _____
Who is your legal next of kin? _____

Family Medical History

Please list any medical condition (i.e. stroke, diabetes, heart disease, cancer, Parkinson's disease, Alzheimer's disease, multiple sclerosis, seizures, brain tumors, aneurysms, neurofibromatosis) that you feel would be important for us to know:

Mother _____ Sibling _____
Father _____ Child _____
Maternal grandparent _____ Paternal grandparent _____
Other _____

Review of Systems Please check any symptoms below that you **currently** have in the following areas:

HEART/VASCULAR	MUSCULOSKELETAL	RESPIRATORY	ENDOCRINE
☐ edema/swelling	☐ painful joints	☐ wheezing	☐ excessive sweating
☐ angina/chest pain	☐ limited mobility	☐ chest pain	☐ hot flashes
☐ poor circulation	☐ chronic muscle pain	☐ persistent coughing	☐ excessive thirst
☐ irregular heart beat	☐ swollen joints	☐ hiccups	☐ urinating at night
☐ palpitations	☐ weakness	☐ sleep apnea	☐ nipple discharge
☐ phlebitis	☐ muscle spasms	☐ shortness of breath	☐ Other _____
☐ clotting/bleeding problems	☐ Other _____	☐ Other _____	
☐ easy bruising			
☐ Other _____			

NEURO	EYE	EAR/NOSE/THROAT	GASTROINTESTINAL
☐ numbness/tingling	☐ blurry vision	☐ ear discharge/drainage	☐ heartburn
☐ balance problems/ unsteady gait	☐ loss of vision	☐ hearing loss/difficulty	☐ difficulty swallowing
☐ tremors/twitching	☐ double vision	☐ ringing in ears/tinnitus	☐ nausea/vomiting
☐ hemorrhage (brain)	☐ eye redness	☐ pain with swallowing	☐ excessive weight loss
☐ difficulty walking	☐ excessive tearing	☐ nosebleeds	☐ excessive weight gain
☐ coordination problems	☐ eyelid drooping	☐ ulcers/sores	☐ constipation
☐ fainting	☐ eye discharge/drainage	☐ decreased smell	☐ loss of appetite
☐ dizziness	☐ Other _____	☐ decreased taste	☐ diarrhea
☐ weakness		☐ Other _____	☐ blood in stools
☐ memory problems			☐ change in bowel habits
☐ headache/migraines			☐ bowel control problems
☐ slurred speech			☐ last colonoscopy _____
☐ loss of consciousness			☐ Other _____
☐ Other _____			

SKIN	URINARY	PSYCHIATRIC	GENITALS / BREASTS
☐ rash	☐ frequent urination	☐ anxiety	☐ tumor
☐ psoriasis	☐ burning during urination	☐ depression	☐ erectile dysfunction
☐ lesions	☐ blood in urine	☐ schizophrenia	☐ enlarged prostate
☐ moles	☐ difficulty with urination	☐ ADHD	☐ nipple discharge
☐ discoloration	☐ bladder control problems	☐ sleep disturbance	☐ menopause
☐ itching	☐ change in bladder function	☐ Other _____	☐ sexual dysfunction
☐ birthmarks	☐ tumor or cysts		☐ date of last mammogram _____
☐ ulcers/pressure sores	☐ kidney stones		☐ LMP _____
☐ Other _____	☐ Other _____		☐ Other _____

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Date of last vaccinations PPD/TB _____ Pneumonia _____ Flu _____ Tetanus _____

Cultural/Linguistic Needs
Are there any language barriers, visual and/or auditory deficits, as well as any cultural or religious customs that may interfere with our ability to provide your care? ☐ No ☐ Yes If yes, please explain:

_____

Do you have a Living Will or Advanced Directive? ☐ Yes ☐ No

To the best of my knowledge, the information that I have supplied on this form is current and complete.

Patient Signature_____ **Date**_____

Physician Signature _____ **Date** _____

I have reviewed the previous information with the patient and changes were noted in the progress notes:

Date	Physician's Signature	Additional Information
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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