JACKSONVILLE
BRAIN & SPINE
Cranial and Spinal Surgery

NEW PATIENT INTAKE AND HISTORY FORM

Today's Date: _____

Name: _____ **Date of Birth:** _____

Local Pharmacy: _____
(Name/City/Phone #)

Mail Order Pharmacy: _____
(Name/City/Phone #)

Are you currently under the care of a Cardiologist? ☐ Yes ☐ No

If you answered "Yes", please give your Cardiologist's name: _____

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____

Timing/Onset: Date of first symptoms / injury? _____

Associated Signs and Symptoms: What are your symptoms? _____

_____

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

___ A-fib	___ Diabetes – Type 1	___ Hepatitis	___ Neuropathy
___ Anemia	___ Diabetes – Type 2	___ High blood pressure	___ Pacemaker
___ Anxiety	___ DVT	___ Hist. of anesthesia reaction	___ Pregnancy
___ Asthma	___ Emphysema	___ Hist. of MRSA infection	___ Seizure
___ Cancer	___ GERD	___ HIV/AIDS	___ Stroke
___ COPD	___ Heart attack	___ Kidney disease	___ Thyroid Disease
___ Depression	___ Heart disease	___ Liver disease	

___ Other: _____

PAST SURGICAL HISTORY:

Please list any procedure(s) you have had in the past. Then write the year, reason, and hospital on the line to the right of it.

☐ **None**

_____

_____

_____

_____

MEDICATION HISTORY:

☐ **I am not currently taking any medications**

List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication	**Dosage**	**How Often**

ALLERGY HISTORY:

☐ **No Known Allergies (NKA)** ☐ **No Known Drug Allergies (NKDA)**

___ Codeine/Codeine Derivatives ___ Latex ___ Penicillins

___ Iodinated Contrast Media ___ Morphine Derivatives ___ Sulfa Drugs

Other: _____

_____

FAMILY HISTORY:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

	Mother	**Father**	**Sister**	**Brother**	**Mother's Parents**	**Father's Parents**
Anemia						
Aneurysm						
Anxiety Disorder						
Asthma						
Cancer						
COPD						
Depression						
Diabetes Mellitus						
DVT						
Emphysema						
GERD						
Heart Disease						
Hepatitis						
High Blood Pressure						
HIV-positive						
Kidney Disease						
Liver Disease						

(FAMILY HISTORY CONTINUED)

Pacemaker	_____	_____	_____	_____	_____	_____
Peripheral Neuropathy	_____	_____	_____	_____	_____	_____
Pulmonary Embolism	_____	_____	_____	_____	_____	_____
Seizure Disorder	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____

Other: _____

SOCIAL HISTORY:

Most recent primary occupation: _____

Dominant hand: ☐ Right handed ☐ Left handed ☐ Ambidextrous

Marital status: ☐ Single ☐ Married ☐ Domestic partnership ☐ Widowed ☐ Separated ☐ Divorced

Current household members: ☐ Patient lives alone

Or list who you live with: _____

Please describe your current tobacco use:

☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Heavy tobacco smoker

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐Never smoker

☐ Unknown if ever smoked

If yes please explain what type of tobacco used and number of cigarette packs per day: _____

_____

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, please indicate what type of beverage and how many servings per day: _____

_____

Vitals (internal Use);

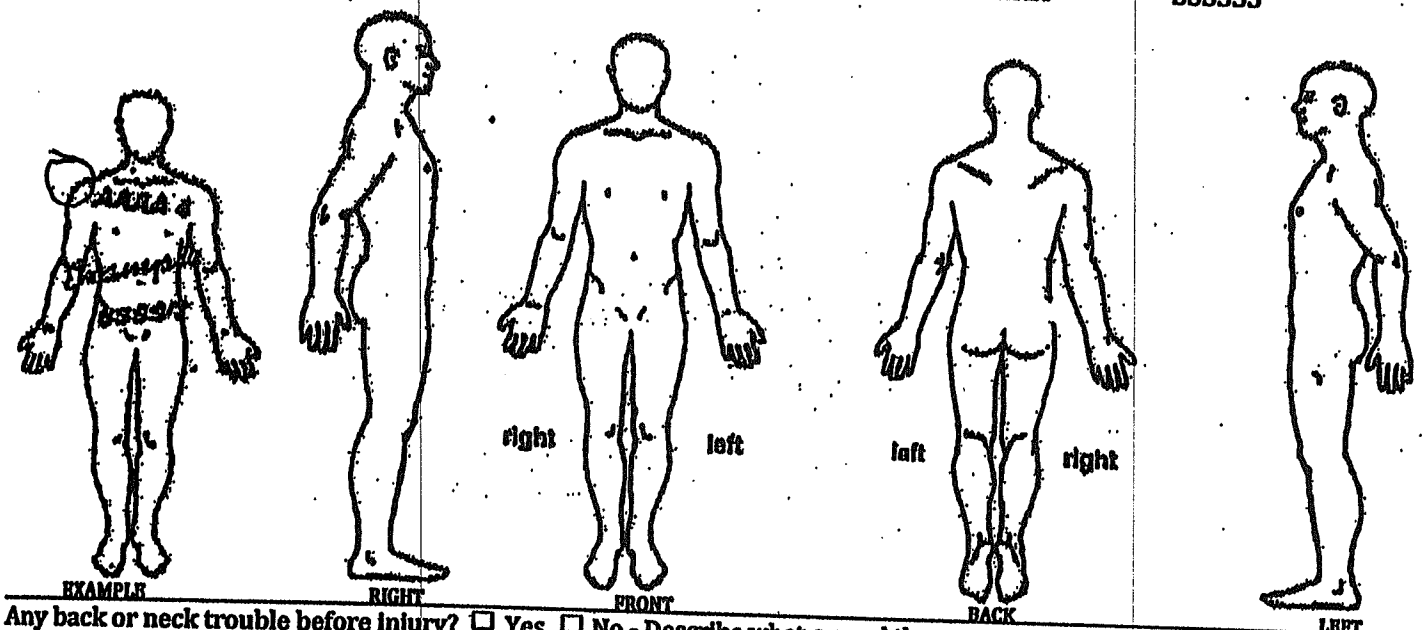
Height: _____ **Weight:** _____ **Blood Pressure:** _____/_____

Heart Rate: _____ **Temp:** _____

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale of 1(discomfort) – 10 (extreme pain). (Circle any area of pain, not represented by a symbol below)

Description >>>>	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol to use >>	NNNNNN	PPPPPPP	BBBBB	AAAA	SSSSSS



Any back or neck trouble before injury? ☐ Yes ☐ No - Describe what caused the onset of your pain: _____

What causes the pain to increase? _____

What causes the pain to decrease? _____

Is the pain☐ better☐ same☐ worse than one month ago? Increases with sneezing or coughing? ☐ Yes ☐ No

Have you had: (please circle)

bowel control changes:	YES	NO	bladder control changes: YES	NO
weakness of legs or feet:	YES	NO	numbness of legs or feet: YES	NO

Have you tried:			**Has that helped?**	
bed-rest:	YES	NO	YES	NO
traction:	YES	NO	YES	NO
chiropractic manipulation:	YES	NO	YES	NO
spine injection:	YES	NO	YES	NO
anti-inflammatory meds:	YES	NO	YES	NO
pain meds:	YES	NO	YES	NO

Have you had:			**WHEN/EXPLANATION**
Physical Therapy:	YES	NO	
Spine X-ray(s):	YES	NO	
CT scan:	YES	NO	
MRI:	YES	NO	
Bone Scan:	YES	NO	
EMG:	YES	NO	
Myelogram:	YES	NO	

The above information is true, to the best of my knowledge.

Patient _____ **Date** _____
(signature)

I have reviewed the above information with patient.

Physician _____ **Date** _____
(printed & signature)