UNIVERSITY OF MINNESOTA
PHYSICIANS

Neurology Clinic
University of Minnesota Medical Center, Fairview
Phillips-Wangensteen Builing
516 Delaware St SE, Clinic 1A
Minneapolis, MN 55455

Neuroscience Services

Patient Health History

PLEASE COMPLETE THIS HEALTH HISTORY QUESTIONNAIRE PRIOR TO YOUR SCHEDULED APPOINTMENT TO ENSURE THAT WE PROVIDE YOU WITH QUALITY CARE.

Apply Patient Label Here

Please bring your questionnaire, medical records, and/or files/CDs to your appointment.
Without this information, we may not be able to complete your evaluation and the provider may ask you to reschedule your appointment.

Name:

Phone: **Fax:**

Address:

City: **State:** **Zip:**

Email Address:

Date of Appointment:

☐ Right-Handed ☐ Left-Handed ☐ Both

REFERRING PHYSICIAN

The physician who recommended you schedule a consultation appointment with us.
In order for us to correspond with your physician we need his/her first and last name and the complete address.

Physician's First Name: **Last Name:**

Mailing Address:

City: **State:** **Zip:**

Phone:

Fax: **Email Address:**

PRIMARY CARE PHYSICIAN

The Primary Care Physician manages the total patient, including preventive care.

☐ **The referring physician is the same as the primary care physician.**

Physician's First Name: **Last Name:**

Mailing Address:

City: **State:** **Zip:**

Phone:

Fax: **Email Address:**

ETHNIC GROUP

☐ African American ☐ Caucasian ☐ Native American
☐ Asian/ Pacific Islander ☐ Hispanic ☐ Other (specify): _____

Do you need an interpreter? ☐ Yes ☐ No Please specify the language: _____

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Patient Health History

CHIEF COMPLAINT What specifically brings you to see the physician today? Please describe your symptoms or the questions you want answered.

HISTORY OF PRESENT ILLNESS

1. **Describe present symptoms (include location, severity, onset, and duration):**

If you have pain or numbness or other sensory changes, please mark the areas on the next page and answer the following questions that apply to you:

At what time of the day are your symptoms worst?

☐ Morning ☐ Later in the day ☐ During the night ☐ Always the same

What activities worsen your symptoms:

☐ Arm(s) overhead ☐ Lifting ☐ Riding and/or driving the car ☐ Sneezing ☐ Straining bowels
☐ Climbing stairs ☐ Movement of the neck ☐ Sitting ☐ Standing ☐ Walking
☐ Coughing ☐ Other (describe):

Have changes occurred in your bladder, bowel, or sexual function? ☐ Yes ☐ No

If yes, please describe:

2. **Describe how it happened or what you think caused it:**

3. **When did the symptoms begin?** Month and Year

4. **If injury/accident related, date of injury/accident:**

5. **Is this injury related to work?** ☐ Yes ☐ No ☐ Uncertain
6. **Have you filed a Workers' Compensation claim?** ☐ Yes ☐ No
7. **Is this injury related to an auto accident?** ☐ Yes ☐ No
8. **Is a lawsuit in progress or being planned?** ☐ Yes ☐ No
9. **Please list all other physicians and chiropractors whom you have seen for this problem and treatments that have been performed:**

Date	Physician	Treatments	Location

10. **Have you been in physical therapy?** ☐ Yes ☐ No

Date Begins	Frequency	Date Ends	Location

11. **What (other) treatments have you already had (injections, acupuncture, etc)?**

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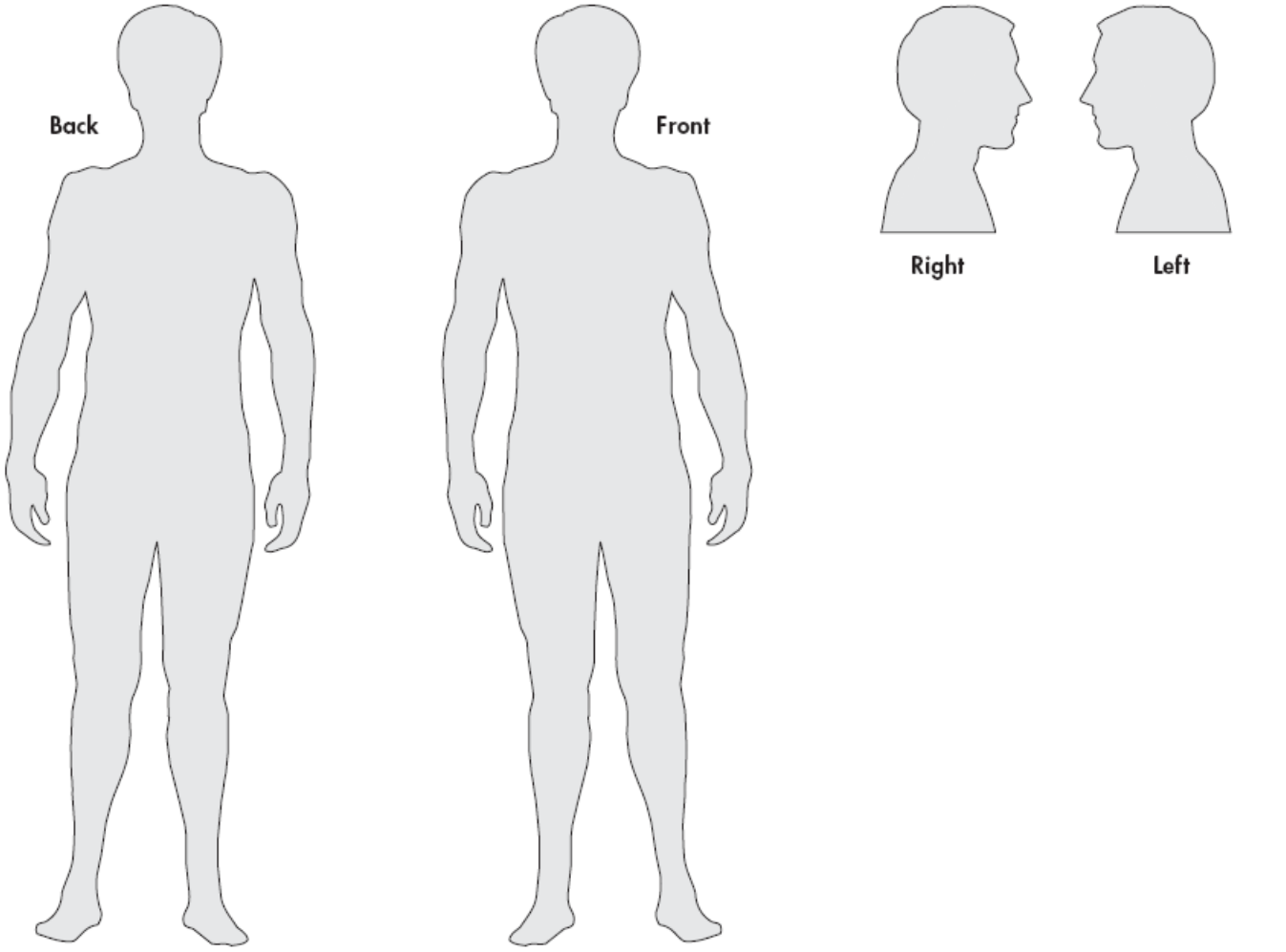
Patient Health History

SENSATION DRAWING

Where is your pain now? Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

Face Pain	Neck Pain	Arm Pain	Back Pain	Leg Pain	Total Score =
%	%	%	%	%	100 %

Symptom =	Ache	Numbness	Pins and Needles	Burning	Radiating Pain
Symbol =	^^^^^^^^^^^^^^	00000000000000	■■■■■■■■■■■■	xxxxxxxxxxxxxxxx	////////////////



How bad is your pain? On a scale of 0 to 10 (0 = no pain, 5 = moderate, 10 = worst pain)

At its very worst	0	1	2	3	4	5	6	7	8	9	10
Now	0	1	2	3	4	5	6	7	8	9	10

Overall, is your pain generally: ☐ Improving ☐ Same ☐ Worsening

Neuroscience Services

Patient Health History

MEDICAL HISTORY List significant illnesses or hospital stays without surgery.

_____

_____

_____

Are you diabetic? ☐ Yes ☐ No

SURGERY AND HOSPITALIZATION HISTORY List previous surgeries and hospitalization, include dates and physicians' names.

_____

_____

_____

Are you pregnant? ☐ Yes ☐ No **How many pregnancies?** _____ **How many births?** _____

Have you had any abortions or miscarriages? ☐ Yes ☐ No If so, please specify and include the number.

_____

FAMILY HISTORY

			Current Age or Age at Death	Health Problems or Cause of Death
Father	☐ Alive	☐ Deceased		
Mother	☐ Alive	☐ Deceased		

	Number	Ages	Serious Illnesses	Number Deceased /Cause
Sisters				
Brothers				
Daughters				
Sons				

Do you know of any blood relative who has had the following illnesses: If yes, check all that apply and provide relationship to patient.

☐ Aneurysm _____ ☐ Chiari Malformation _____ ☐ Lung Disease _____

☐ Brain Hemorrhage _____ ☐ Diabetes _____ ☐ Seizures _____

☐ Brain Tumor _____ ☐ Heart Disease _____ ☐ Stroke _____

☐ Cancer _____

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Patient Health History

CURRENT MEDICATIONS Please complete the medication list below with the medications you are currently taking. If you have difficulty completing this form please bring your medications with you to your appointment. Include name, dose and frequency.

Medication	Dosage	How often you take it?
Example: Aspirin	325 mg	One tablet per day

ALLERGIES Include medications, soaps, foods, tapes, latex, or dyes.

Do you wear a prosthesis, pacemaker, or metal implant? If yes, please specify.

Are you claustrophobic (having fears or anxiety in a confined environment, e.g., MRI)?

SOCIAL HISTORY AND HABITS

1. ☐ Married ☐ Divorced ☐ Single ☐ Widow ☐ Widower
2. **Who lives with you?** _____
3. **If you have surgery, who can help you when you go home from the hospital?** _____
4. **Do you smoke?** ☐ Yes ☐ No If so, how much? _____ Did you ever quit? ☐ Yes ☐ No If so, when did you quit? _____
   Are you interested in assistance with quitting? If so, what type of assistance? ☐ Phone counseling ☐ Medication ☐ Self-help information
5. **Are you exposed to second hand smoke?** ☐ Yes ☐ No
6. **Do you use alcohol?** ☐ Yes ☐ No If so, how much? _____ When did you quit? _____
7. **Do you use any "street" drugs?** ☐ Yes ☐ No If so, how frequently? _____ Did you ever use any? ☐ Yes ☐ No
8. **Are you retired?** ☐ Yes ☐ No
9. **Are you employed?** ☐ Yes ☐ No ☐ Full time ☐ Part time ☐ Disabled (Last day of work) _____

Present and/or former occupation _____

Describe the type of work you do (e.g., lifting, standing, sitting, bending) _____

How many years have you done this job? _____ **Have you lost work due to this current injury?** ☐ Yes ☐ No

Do you have any other appointments within the Fairview system? ☐ Yes ☐ No

If yes, please check: ☐ University of Minnesota Medical Center, Fairview ☐ Fairview facilities

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Patient Health History

GENERAL REVIEW OF SYSTEMS

Please check those items that pertain to you during your lifetime.

Last dental visit:

_____

Last visit to an ophthalmologist:

_____

Last complete physical exam with lab work (EKG, etc.):

_____

Allergies

- ☐ Asthma
- ☐ Hay fever

Other: _____

Cardiovascular

- ☐ Chest pain
- ☐ Difficulty breathing at night
- ☐ Heart murmur
- ☐ Irregular heart beat
- ☐ Pacemaker
- ☐ Poor circulation
- ☐ Swollen legs or feet
- ☐ Varicose veins

Other: _____

Ears/Nose/Mouth/Throat

- ☐ Bleeding gums
- ☐ Difficulty swallowing
- ☐ Earache
- ☐ Ear discharge
- ☐ Hearing loss:
  - ☐ Right ☐ Left
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus problems

Other: _____

Endocrine

- ☐ Excessive hunger/thirst
- ☐ Intolerance to warm room
- ☐ Loss of libido
- ☐ Multiple broken bones
- ☐ Rapid weight gain
- ☐ Rapid weight loss
- ☐ Spontaneous nipple discharge
- ☐ Thyroid problems

Other: _____

Eyes

- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Eye infections
- ☐ Vision flashes or halos

Other: _____

Gastrointestinal

- ☐ Black stools
- ☐ Blood in stools
- ☐ Chronic diarrhea
- ☐ Heartburn
- ☐ Hepatitis A, B, C (circle one)
- ☐ Increasing constipation
- ☐ Liver disease
- ☐ Nausea
- ☐ Vomiting

Other: _____

General

- ☐ Chills/sweats/fever
- ☐ Difficulty sleeping
- ☐ Headache
- ☐ Recent fatigue
- ☐ Recent weight gain
- ☐ Recent weight loss

Other: _____

Genitourinary

- ☐ Difficulty to initiate/retention
- ☐ Discharge from penis/vagina
- ☐ Incontinence (loss of urine)
- ☐ Prostate problem
- ☐ Urgency
- ☐ Urinary tract infection

Other: _____

Hematologic/Lymphatic

- ☐ Easy skin bruising
- ☐ Marked fatigue
- ☐ Prolonged bleeding from cuts or tooth extractions
- ☐ Tender glands/lymph nodes

Other: _____

Mood

- ☐ Anxiety
- ☐ Depression
- ☐ Panic attacks
- ☐ Restlessness

Other: _____

Musculoskeletal

- ☐ Arthritis
- ☐ Joint swelling in:
  - ☐ Hands ☐ Hips
  - ☐ Wrists ☐ Knees
  - ☐ Joints
- ☐ Muscle tenderness in:
  - ☐ Arms ☐ Legs
- ☐ Osteoporosis

Other: _____

Neurological

- ☐ Fainting
- ☐ Headaches
- ☐ Numbness of arms or legs
- ☐ Problem with memory
- ☐ Seizures
- ☐ Tingling of hands, arms or legs

Other: _____

Respiratory

- ☐ Chronic cough
- ☐ Coughing of blood
- ☐ Night sweats
- ☐ Short of breath
- ☐ Tuberculosis (TB)
- ☐ Wheezing

Other: _____

Skin

- ☐ Chronic skin itching
- ☐ Color changes of hands or feet in the cold
- ☐ Poor scarring/non-healing ulcer
- ☐ Skin rashes or hives
- ☐ Unusual moles

Other: _____

SIGNATURE

of the individual completing the form.

Name: _____ **Date:** _____

Signature: _____