ATLANTIC BRAIN AND SPINE

Office Use Arrival:_____
Checked In: _____
Roomed: _____
___CD(s) Scanned: ☐

Follow Up Patient History Inventory

Patient Name:_____Date of Birth:_____Date: _____

Have you had any change in your medical history since our office last saw you? (i.e. new diagnosis, new medication, new allergy to medication, or surgery) NO YES

If yes, please provide information to include dates:

_____

_____

_____

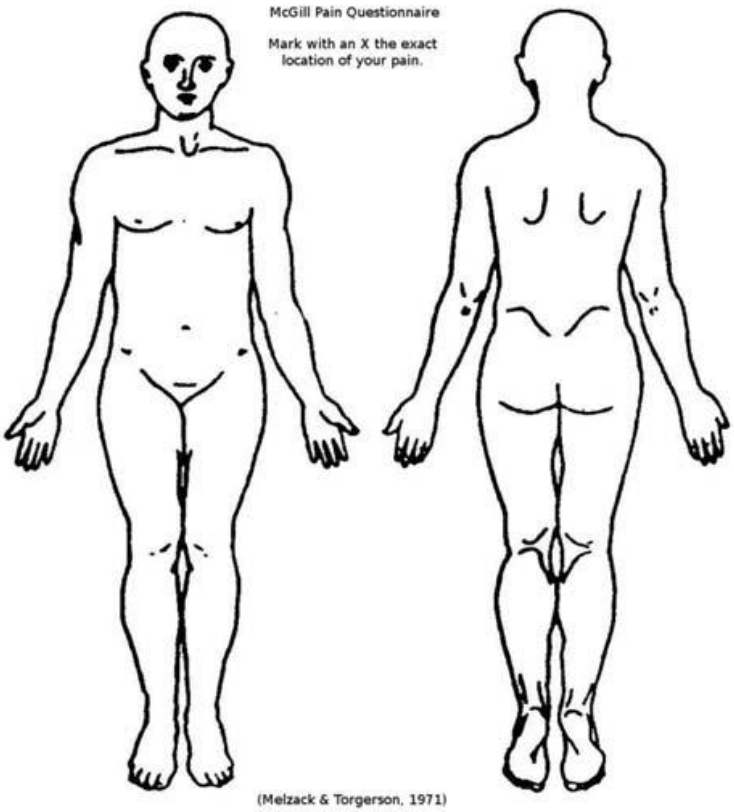
Have you fallen in the past year?_____If yes, how many times:_____Did the fall result in injury? _____

Overall, would you say you are (circle one): improving worsening about the same

How bad is your pain now? (Circle ONE)

0 1 2 3 4 5 6 7 8 9 10
No pain Worst Possible Pain

Using the **symbols** shown, mark the areas on the figure that show **where** you feel the described sensations.



Ache:
^^^^^^^^
Burning:
XXXXXXXX

Numbness:
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Pins & Needles:
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Stabbing:
======

	Better		Worse		No Change	
Standing						
Sitting						
Walking						
Lying down						
Raising from chair						
Physical activity						

Please check ***ALL*** symptoms that apply for you ***RIGHT NOW***,

IF YOU DO NOT HAVE ANY SYMPTOMS PLEASE CHECK HERE: ☐

CONSTITUTIONAL
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Fever

EYES
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Cataracts

EAR, NOSE, THROAT
- ☐ Difficulty Hearing
- ☐ Ringing in Ears
- ☐ Dizziness
- ☐ Sinus Trouble

CARDIOVASCULAR
- ☐ Murmur
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Fainting Spells
- ☐ Shortness of Breath
- ☐ Difficulty Lying Flat
- ☐ Swelling Ankles/Other

ENDOCRINE
- ☐ Loss of Hair
- ☐ Heat/Cold Intolerances
- ☐ Change in Nails

RESPIRATORY
- ☐ Cough
- ☐ Coughing Blood
- ☐ Wheezing

GASTROINTESTINAL
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Difficulty Swallowing
- ☐ Jaundice
- ☐ Abdominal Pain
- ☐ Black Stools

GENITOURINARY
- ☐ Pain Urinating
- ☐ Urinary Frequency
- ☐ Nighttime Urination
- ☐ Difficulty Urinating
- ☐ History Kidney Stone
- ☐ History STD
- ☐ Abnormal Discharge
- ☐ Blood in Urine

FEMALE ONLY
- ☐ Menopause
- ☐ Are Your Periods Regular?

HEMATOLOGIC/LYMPH
- ☐ Prolonged Bleeding

NEUROLOGICAL
- ☐ Seizures
- ☐ Weakness/Paralysis
- ☐ Numbness
- ☐ Tremors
- ☐ Headache
- ☐ Memory Loss
- ☐ Trouble Finding Words
- ☐ Balance Problems

MUSCULOSKELETAL
- ☐ Joint Pain/Swelling
- ☐ Stiffness
- ☐ Muscle Pain
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Shoulder Pain

PSYCHIATRIC
- ☐ Anxiety/Depression
- ☐ Mood Swings
- ☐ Difficult Sleep

ALLERGIC/IMMUNOLOGIC
- ☐ Hay Fever/Asthma
- ☐ Hives/Eczema

SKIN
- ☐ Rash
- ☐ Lesions

Please fill this out EVERY time, for most accurate/current pharmacy. Where to send prescription requests:

Pharmacy ⤵	**Phone** ⤵	**City** ⤵

In order to better manage your healthcare needs, please list any medical providers that you'd like to receive your office notes from your appointment(s).

Primary Physician:	Phone:	Location:
Physician Name:	Phone:	Location:
Physician Name:	Phone:	Location:

I authorize Atlantic Neurosurgical & Spine Specialist to release notes from this office to the list of providers above.

Patient Signature:_____ **Date:** _____