

THE CENTER FOR SPINE HEALTH

Division of Radiology Associates of Northern Kentucky

Eric A. Brandser, M.D. | Kirk M. Doerger, M.D. | Darren R. Hurst, M.D.
 Brian C. Lawler, M.D. | Attef A. Mikhail, M.D. | Sean D. Wells, M.D.

MEDICAL HISTORY

PATIENT: _____ DOB: _____

Symptoms: _____ Date began _____

MEDICAL HISTORY / SYSTEMIC REVIEW	Y E S	N O		Y E S	N O
Diabetes:			Social History:		
Insulin _____ Oral Medication _____			Single		
Tobacco Use – Past or Present – Amount			Married		
Alcohol Use – Past or Present – Amount			Divorced		
Skin:			Widowed		
Skin Disease			Separated		
Jaundice			Significant Other		
Hives, Eczema or Rash					
Head – Eyes – Ears – Nose – Throat:			With whom do you live?		
Dry Eyes or Mouth					
Bleeding Gums – Frequent or Constant			Surgery:		
Blurred Vision			Have you ever had surgery?		
Date of Last Eye Exam					
Sneezing or Runny nose			Heart – Date		
Nosebleeds -- Frequent					
Chronic Sinus Trouble					
Ear Disease					
Impaired Hearing					
Dizziness or sensation of room spinning			Other – Date		
Frequent or severe Headaches					
Respiratory:					
Asthma or Wheezing					
Difficulty Breathing					
Any trouble with Lungs			Other – Date		
Pleurisy or Pneumonia					
Cough up Blood (ever)					
Cardiovascular:					
Chest Pain, Pressure, or Tightness					
Shortness of Breath with walking or lying down			Other – Date		
Difficulty walking two blocks					
Palpitations					
Swelling of hands, feet or ankles					
Heart Murmur					
Gastrointestinal:			Medical History:		
Vomiting blood or food					
Gallbladder disease			Other – Date		
Change in appetite					
Hepatitis/ Jaundice					
Painful bowel movements					
Bleeding with bowel movements					
Black Stools			Other – Date		
Hemorrhoids or piles					
Recent change in bowel habits					
Frequent diarrhea					
Heartburn or indigestion			Medications:		
Cramping or pain in the abdomen					
Does food stick in throat					
Endocrine:					
Hormone therapy					
Any change in hat or glove size					
Any change in hair growth			Drug Allergies List:		
Have you become colder than before or skin become dryer					

FORM COMPLETED BY: _____ Date: _____