

Please fill out the following information and bring it with you on day of your appointment. Completing this form ahead of time allows us to spend as much face-to-face time as possible on the reason you have come to see us.

1. Please briefly explain the major problem/symptom that brings you to the doctor.

2. Do you have now, or have you previously been diagnosed with, any of the below conditions? Do you take medicines that treat any of the following conditions? If either is true, please place an "X".

	Anxiety
	Asthma
	Atrial fibrillation
	Benign prostatic hypertrophy (BPH)
	Blood clots
	Cancer (Type: _____) Circle treatment(s) received: Chemo Radiation Surgery
	Carpal tunnel syndrome Circle side: Right Left Both
	Cerebrovascular accident (stroke) Year(s): _____ Symptoms: _____
	Concussion
	Congestive heart failure ("CHF")
	COPD
	Coronary artery disease
	Dementia
	Depression
	Diabetes
	Fibromyalgia
	GERD ("reflux")

	High cholesterol (hyperlipidemia)
	High blood pressure (hypertension)
	Hypercoagulable state
	Liver disease
	Low back pain Migraines or headaches Age began: _____ How often occur? _____ How long last? _____
	Meds taken: _____
	Multiple Sclerosis Myocardial infarction ("heart attack") Year(s): _____
	Neck pain
	Neuropathy
	Osteoarthritis or other arthritis
	Osteoporosis
	Parkinson's Disease
	Peptic ulcer disease
	Renal disease (kidney disease)
	Seizure disorder
	Thyroid disease
	Tremor
	Vertigo or dizziness

3. List any surgery or procedure you have had. Please also write in the approximate year it occurred to the right of the category name.

	Angioplasty
	Angio with stent
	Appendectomy
	Arthroscopy of knee
	Back surgery Circle location: Neck Mid-back Low back
	CABG ("coronary or heart bypass")
	Carpal tunnel release Circle side(s): Right Left
	Cataract extraction
	Cholecystectomy ("gall bladder removal")
	Colectomy or colostomy
	Gastric bypass
	Hernia repair
	Hip replacement Circle side(s): Right Left
	Knee replacement Circle side(s): Right Left
	LASIK
	Liver biopsy
	ORIF ("open reduction, internal fixation")
	Pacemaker
	Small bowel resection
	Thyroidectomy
	Tonsillectomy

Women:	
	Breast augmentation
	Bilateral tubal ligation
	Breast biopsy
	Cesarean section ("C-section")
	D and C
	Hysterectomy Circle type: Ovaries removed Ovaries left intact Unknown
	Mastectomy
	Myomectomy (removal of fibroids)
	Reduction breast surgery

Men:	
	Prostate biopsy
	TURP ("transurethral resection of prostate")
	Vasectomy

4. Have you ever been hospitalized for a nonsurgical problem? If so, what was the problem, when and where were you hospitalized?

5. Are you allergic to any medications?

Yes _____ No _____ If yes, list medication and reaction (for example, "rash").

6. Are you a smoker?

Yes _____ No _____ Former _____

If either current or former, list:

Average # packs per day _____

Approximate years smoked _____

If former, year quit _____

7. Do you drink alcoholic beverages?

Yes _____ No _____ Former _____

If either current or former, list:

Frequency (daily, weekly, etc) _____

Type (beer, wine, liquor) _____

If former, year quit _____

8. Which hand do you write with and perform other fine motor activities (using scissors, etc)?

Right _____ Left _____ Both _____

9. Do you drink caffeinated coffee or tea?

Yes _____ No _____

If yes, average # of cups per day _____

10. Do you drive a car or other motorized vehicle?

Yes _____ No _____

11. Do you live by yourself or with others? Live in a home/apartment or senior center?

12. What kind of work do you do (or did in the past)? Are you full-time, part-time, disabled, unemployed, self-employed, etc? Do you do primarily desk work or physical labor?

13. So that we may better assist you, please list the highest level of education achieved (i.e., high school diploma, college degree, graduate work, etc).

14. What is your family history of illnesses?

Illness	Who has or had this illness?
	Father, mother, sister, brother, grandparent, etc?
Cancer	
Type(s):	
Dementia or memory loss	
Diabetes	
Heart disease	
High blood pressure	
Migraine	
Parkinson's	
Seizure or epilepsy	
Tremor	
Other significant medical problem	
Type(s):	

15. What are your family members' ages? If deceased, list age and cause of death.

Mother's age: _____
 Father's age: _____
 Siblings' ages: _____

 Children's ages: _____

14. Have you ever seen a neurologist in the past?

Yes ____ No ____

If yes, who did you see? What was the reason? When?

15. Please list approximate dates of any recent (within the last six months) lab work, x-rays, or other tests and the results of these tests if they are known to you. Were they done at a John Muir facility? Please bring a copy of the test reports with you at time of visit.