CENTRAL TEXAS BRAIN & SPINE

HISTORY OF PRESENT ILLNESS (CRANIAL)

☐ **Richard B. Stovall, MD** ☐ **Judson H. Cook, MD**

Name:	Age: Sex: ☐M ☐F	Height/Weight:	Right or Left Handed?:
Referring Physician:	Primary Care Physician (if different):		Preferred Pharmacy:

Reason for visit:

Are you experiencing:

- ☐ Headaches
- ☐ Nausea/Vomiting
- ☐ Visual Changes
- ☐ Difficulty with Speech
- ☐ Hearing Loss
- ☐ Difficulty swallowing, choking or gagging
- ☐ Memory loss
- ☐ Seizures
- ☐ Poor Balance
- ☐ Weakness/Paralysis: if yes, where? _____
- ☐ Numbness /Tingling: if yes, where? _____

Please describe when and how your symptoms began:

Have your symptoms improved or worsened?

Have you received any treatment for your symptoms?

If yes, please list physician's names and describe the treatment:

Name: _____ DOB: _____

Medical History *(Please list all existing medical conditions or any condition requiring medication)*:

Surgical History *(Please list all previous surgeries)*:

Medications *(Please list all medications and their dosage if taken regularly)*:

Allergies *(Please list all medication allergies)*:

Family Medical History *(Please list all illnesses diagnosed in family members):*

Social History *(Please answer questions below)*:

Are you currently employed? ☐ Yes ☐ No What is your occupation? _____

Are you married? ☐ Yes ☐ No Children? ☐ Yes ☐ No List ages: _____

Do you smoke? ☐ Yes ☐ No If so, how much/often? _____ # of years? _____

Do you use illicit drugs? ☐ Yes ☐ No If so, how much/often? _____ # of years? _____

Do you drink alcohol? ☐ Yes ☐ No If so, how much/often? _____ # of years? _____

Worker's Comp Detail *(Please answer questions below)*:

Is this a work related injury? ☐ Yes ☐ No

Is there an attorney or lawsuit involved? ☐ Yes ☐ No

Other Health Complaints:

- ☐ Runny nose
- ☐ Sore throat
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Chronic or frequent coughs
- ☐ Wheezing
- ☐ Nausea
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Black/tarry stools
- ☐ Diarrhea
- ☐ Urinary loss control
- ☐ Difficulty starting/ending stream
- ☐ Increase urinary frequency
- ☐ Urinary irregularity
- ☐ Urinary urgency
- ☐ Joint swelling
- ☐ Joint stiffness/Pain
- ☐ Bruising
- ☐ Tingling in limbs
- ☐ Paralysis
- ☐ Loss of consciousness
- ☐ Seizures
- ☐ Depression
- ☐ Anxiety
- ☐ Excessive thirst
- ☐ Night sweats
- ☐ Swollen glands
- ☐ Fever
- ☐ Chills
- ☐ Change in sleeping habits
- ☐ Weight change
- ☐ Unusual stress
- ☐ Other symptoms not mentioned above:

FOR PHYSICIAN USE ONLY:

I have read and reviewed the patient's health history _____ / Date _____