NEUROVERSION
Break the cycle of pain

Past Medical History

Name: ______________________ DOB: ______________

Current Medications

List ALL medications that you currently take. Include name, dosage, frequency, and prescriber (if known). Examples include anticoagulants (blood thinners), blood pressure medication, supplements, vitamins, topicals (creams), CBD products, etc. Please provide an additional or separate list if you run out of room below.

Name	Dose	Frequency	Prescriber

MEDICAL HISTORY

Please check all current and past medical problems that apply to you:

□ High blood pressure
□ Asthma or wheezing
□ Heart attack
□ Chronic cough
□ Liver disease
□ Diabetes
□ Seizure or epilepsy
□ Chest pain
□ Arthritis
□ Kidney disease
□ Stroke/TIA
□ Bleeding problems
□ Peripheral vascular disease

□ Cancer, please specify: ______________________

Status: □ Active □ In remission *Current treatment:* □ Chemotherapy □ Radiation therapy □ N/A

□ Other: ______________________

In the past year, have you had any falls:
□ No falls in the past year □ One fall without injury in the past year □ One fall with injury in the past year
□ Two or more falls without injury in the past year □ Two or more falls with injury in the past year

ALLERGIES

Please list all known drug allergies. If you run out of room, please provide a separate list:

Medication/Drug	Reaction
□ No known drug allergies	
□ Contrast dye	

SURGICAL HISTORY

Please list past surgeries. If you run out of room, please provide a separate list:

Type/Name of Surgery	Date (approximate)

HOSPITALIZATION

Have you *ever* been hospitalized? □ Yes □ No
If YES, please provide brief description below. If you run out of room, please provide a separate list:

Date (approximate)	Location	Reason

FAMILY HISTORY

Please select/list all medical problems that affect family members:

Father:

□ Heart disease □ Hypertension □ Diabetes mellitus □ Cancer □ Substance abuse □ Mental illness

□ Other ______________________________

Mother:

□ Heart disease □ Hypertension □ Diabetes mellitus □ Cancer □ Substance abuse □ Mental illness

□ Other ______________________________

Brother(s):

□ Heart disease □ Hypertension □ Diabetes mellitus □ Cancer □ Substance abuse □ Mental illness

□ Other ______________________________

Sister(s):

□ Heart disease □ Hypertension □ Diabetes mellitus □ Cancer □ Substance abuse □ Mental illness

□ Other ______________________________

Other family member(s): ______________________________

□ Heart disease □ Hypertension □ Diabetes mellitus □ Cancer □ Substance abuse □ Mental illness

□ Other ______________________________

□ **Adopted** □ **Family history unknown**

SOCIAL HISTORY

Are you a:

□ Nonsmoker □ Former smoker, date quit: ____________ □ Current smoker

Did you have a drink containing alcohol in the past year? □ Yes □ No

If YES, how often did you have a drink?

□ Monthly or less □ 2-4 times a month □ 2-3 times a week □ 4 or more times a week

If YES, how many drinks did you have on a typical day when you were drinking in the past year?

□ 1-2 drinks □ 3-4 drinks □ 5-6 drinks □ 7-9 drinks 10 or more drinks

If YES, how often did you have 6 or more drinks on one occasion in the past year?

□ Never □ Less than monthly □ Monthly □ Weekly □ Daily

Do you have a history of alcoholism? □ Yes □ No

Have you ever been to a detox program for alcohol abuse? □ Yes □ No

Have you attended Alcoholics Anonymous? □ Yes □ No

Living arrangements:

□ Alone □ Spouse/partner □ Friends □ Children □ Other

Highest education level achieved:

□ Graduate or professional training (degree obtained)
□ College graduate (degree obtained)
□ Partial college training
□ High school diploma
□ GED or trade-technical social graduate
□ Partial high school (10th through 12th grade)
□ Partial junior high school (7th through 9th grade)
□ Elementary school (6th grade or less)

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	◻	◻	◻	◻
Feeling down, depressed, or hopeless	◻	◻	◻	◻
Trouble falling or staying asleep, or sleeping too much	◻	◻	◻	◻
Feeling tired or having little energy	◻	◻	◻	◻
Poor appetite or overeating	◻	◻	◻	◻
Feeling bad about yourself or that you are a failure, or have let yourself or your family down	◻	◻	◻	◻
Trouble concentrating on things, such as reading the newspaper or watching television	◻	◻	◻	◻
Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	◻	◻	◻	◻
Thoughts that you would be better off dead or of hurting yourself in some way	◻	◻	◻	◻

Have you ever had psychiatric, psychological, or social work evaluation or treatments for any problem?

◻ Yes ◻ No

If YES, when? ______________________________

Have you ever considered suicide?

◻ Yes ◻ No

If YES, when? ______________________________

Review of Systems

Over the last 2 weeks, have you had any of the following symptoms:

General/Constitutional:

◻ Change in appetite ◻ Chills ◻ Fatigue ◻ Fever ◻ Headache
◻ Lightheadedness ◻ Night sweats ◻ Sleep disturbance ◻ Weight gain ◻ Weight loss
◻ No symptoms

Allergy/Immunology:

◻ Cough ◻ Rash ◻ Sneezing ◻ No symptoms

Ophthalmologic:

◻ Blurred vision ◻ Eye problems ◻ No symptoms

ENT:

◻ Dry mouth ◻ Nosebleed ◻ Ringing in the ears ◻ No symptoms

Endocrine:

◻ Cold intolerance ◻ Diabetes ◻ Difficulty sleeping
◻ Excessive sweating ◻ Heat tolerance ◻ Hot flashes
◻ No symptoms

Respiratory:

◻ Asthma ◻ Breathing problems
◻ Shortness of breath at rest ◻ Shortness of breath with exertion
◻ No symptoms

Cardiovascular:

◻ Chest pain at rest ◻ Chest pain with exertion ◻ High blood pressure
◻ Irregular heartbeat ◻ Swelling in hands/feet ◻ No symptoms

Gastrointestinal:

◻ Abdominal pain ◻ Blood in stool ◻ Change in bowel habits ◻ Constipation

◻ Decreased appetite ◻ Diarrhea ◻ Difficulty swallowing ◻ Nausea
◻ No symptoms

Hematology:
◻ Bleeding problems ◻ No symptoms

Genitourinary:
◻ History of kidney stones ◻ Difficulty urinating ◻ Kidney problems
◻ No symptoms

Musculoskeletal:
◻ Arthritis ◻ Back problems ◻ Carpal tunnel ◻ History of gout ◻ Joint stiffness
◻ Leg cramps ◻ Muscle aches ◻ Painful joints ◻ Swollen joints ◻ Weakness
◻ No symptoms

Peripheral Vascular:
◻ Blood clots in legs ◻ Cold extremities
◻ Decreased sensation in extremities ◻ Pain/cramping in legs after exertion
◻ No symptoms

Skin:
◻ Discoloration ◻ Hair changes ◻ Itching ◻ Nail changes ◻ No symptoms

Neurologic:
◻ Balance difficulty ◻ Difficulty speaking ◻ Fainting ◻ Loss of strength
◻ Memory loss ◻ Pain ◻ Stroke ◻ No symptoms

Psychiatric:
◻ Auditory hallucinations ◻ Visual hallucinations ◻ Depressed mood
◻ Loss of appetite ◻ Psychiatric condition ◻ Suicidal thoughts
◻ No symptoms

To the fullest of my knowledge, I have accurately and truthfully completed my health history.

Signature: ______________________________ Date: ______________