WEST INDIAN NEUROSCIENCES

Phillip G. St. Louis, M.D., FACS, FAANS
wintt@ain.md

Health History

Date:_____

Name: *Last* _____ *First* _____ *MI* _____

Age: _____ Height: _____ Weight: _____ ☐ Left Handed ☐ Right Handed

Employer: _____ Occupation: _____

Referring Physician

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: (___) _____
Fax Number: (___) _____

Primary Care Physician

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: (___) _____
Fax Number: (___) _____

Chief Complaint-(The main reason for your visit)

☐ Pain--Location: _____
☐ Numbness --Location: _____
☐ Weakness --Location: _____
☐ Other: _____

Describe the quality of the symptom: ☐ Sharp ☐ Dull ☐ Burning ☐ Aching
☐ Other:_____

Describe the intensity of the symptom: ☐ Mild ☐ Moderate ☐ Severe
☐ Other: _____
Describe the frequency of your symptom: ☐ Constant ☐ Intermittent ☐ Daily
☐ Other: _____
What makes it better? _____
What makes it worse? _____

_____

How long have you had this problem? _____

Your problem is the result of: ☐ Automobile Incident ☐ Work Incident ☐ Unknown
Since the start of your problem, it has gotten: ☐ Worse ☐ Better ☐ Stayed the Same
Have you ever had similar symptoms prior to above: ☐ No ☐ Yes
If yes, when: _____

Which of the following, if any, have been done within the last year? ☐ MRI ☐ CT ☐ Myelogram
☐ EMG/NCT ☐ Nerve Blocks ☐ Angiogram ☐ Physical Therapy
☐ Other _____
Which of the above, if any, provided relief? _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Not Employed ☐ Retired
Work Status: ☐ Regular Duty ☐ Light Duty
Work Restrictions: _____
Have you been to work since the symptoms started? ☐ Yes ☐ No ☐ Off & On

---

Medical Problems: ☐ COPD/Lung ☐ Diabetes ☐ Heart Disease/Attack ☐ High Blood Pressure
☐ Kidney ☐ Stroke ☐ Thyroid ☐ Cancer_____ ☐ Other _____

Patient Name: _____ **Date:** _____

ALL Surgeries and/or Hospitalization	Year	Complications

Have you ever had problems with anesthesia? ☐ Yes ☐ No If yes, explain. _____

Medications (Prescription & Over the Counter)	Dosage (Mg)	Frequency (# time/day)	Reason Condition Treated	Prescribing Doctor

Do you take aspirin or any aspirin products? _____ If yes, How much and how often?_____
Do you take any blood thinners (e.g. Plavix, Coumadin (Warfarin) Heparin, Lovenoxx, etc.)? _____

KNOWN ALLERGIES:

Family Member	Alive	Deceased	Age	Medical History/Cause of Death
Grandmother (Mom's)	A	D		
Grandfather (Mom's)	A	D		
Grandmother (Dad's)	A	D		
Grandfather (Dad's)	A	D		
Father	A	D		
Mother	A	D		
Siblings: No. ☐ ☐ M ☐ F	A ☐	D ☐		
Children No. ☐ ☐ M ☐ F	A ☐	D ☐		

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated

Are you pregnant? _____ Breastfeeding ____ Do you live alone?_____Who lives with you? _____

Current smoker	☐ Yes	☐ No	Packs /day ….. No. of Years……..
Past smoker	☐ Yes	☐ No	Quit Date: ……..
Alcohol	☐ Yes	☐ No	No. of drinks/day/week ……
Caffeine	☐ Yes	☐ No	No. of cups/day ……
Recreational drugs	☐ Yes	☐ No	Have you use needles to inject drugs ☐ Yes ☐ No
Regular exercise	☐ Yes	☐ No	

Are you at risk for Immune Deficiency (eg: HIV/AIDS sexual orientation/behaviour, drug abuse, previous blood transfusion, chemo?) ☐ No ☐ Yes Please explain: ……..

Are you satisfied with your weight: ☐ Yes ☐ No How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Do you eat or drink four servings of dairy or soy daily or take calcium supplements? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Patient Name: _____ **Date:** _____

Please indicate (by check mark) below which, if any, medical history you have experienced within the last 6 months.

Constitutional
- ☐ Fever
- ☐ Weight loss
- ☐ Excessive fatigue
- ☐ Chills/night sweats

Eyes
- ☐ Wear Glasses
  Date of Last Exam: _____
- ☐ Glaucoma/Partial Vision Loss
- ☐ Cataracts
- ☐ Painful Vision

Ear, Nose, Throat and Mouth
- ☐ Hearing loss
- ☐ Ear infection
- ☐ Ringing in ears
  Circle one: Left Right Both
- ☐ Balance disturbance (vertigo, spinning, etc)
- ☐ Nosebleeds
- ☐ Nasal congestion
- ☐ Nasal drainage
  Amount _____ Color _____
- ☐ Inability to smell
- ☐ Sinus problems
- ☐ Sinus headaches
- ☐ Sore throats
- ☐ Mouth sores

Cardiovascular
- ☐ Chest pain or angina
- ☐ High blood pressure
- ☐ Irregular pulse
- ☐ Heart murmur
- ☐ High cholesterol
- ☐ Swelling in feet or hands
- ☐ Leg pain while walking

Respiratory
- ☐ Asthma
- ☐ Chronic cough
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Lung caner
- ☐ Bloody sputum

Gastrointestinal
- ☐ Indigestion of pain with eating
- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in your vomit
- ☐ Liver disease
- ☐ Jaundice
- ☐ Abdominal pain
- ☐ Change in your bowel habits
- ☐ Ulcers or gastritis
- ☐ Colon cancer

Genitourinary
- ☐ Urinary tract infections
- ☐ Painful urination
- ☐ Blood in your urine
- ☐ Difficulty starting and stopping urination
- ☐ Stream
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Prostate cancer (males)
- ☐ Endometriosis (females)
- ☐ Uterine or cervical cancer (females)

Musculoskeletal
- ☐ Neck pain
- ☐ Arm or leg weakness
- ☐ Back pain
- ☐ Arm or leg pain
- ☐ Joint pain or swelling
- ☐ Arthritis
- ☐ Muscle pain or tenderness in joints

Integumentary
- ☐ Skin diseases
- ☐ Skin cancer
- ☐ Breast pain, tenderness or swelling
- ☐ Nipple discharge (females)

Neurological
- ☐ Fainting spells or blacking out
- ☐ Seizures- Date of last one _____
- ☐ Problems with memory
- ☐ Disorientation
- ☐ Difficulty with speech
- ☐ Inability to concentrate
- ☐ Double to blurred vision
- ☐ Face weakness
- ☐ Coordinator in arms and/or legs
- ☐ Headaches
- ☐ Stroke

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Other Psychiatric Disorder _____

Endocrine
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Increase appetite
- ☐ Excessive thirst or urination
- ☐ Hormone problems

Hematology/ Lymphatic
- ☐ Anemia
- ☐ Hemophilia
- ☐ Bleeding tendencies
- ☐ Persistent swollen glands or lymph nodes
- ☐ Blood transfusion

Allergic/Immunologic
- ☐ Food allergies
- ☐ Inhalant allergies (nasal)
- ☐ Immunology disorders