East Bay Neurosurgery and Spine **A Medical Corporation**
2510 Webster St, Suite 300
Berkeley, CA 94705

MEDICAL HISTORY FORM **DATE:_____**

NAME: _____ AGE_____ HEIGHT_____WEIGHT_____

Please describe the main problem that brings you here today:

How long has this problem been bothering you?

Where is your pain?

Rate Your Most Common Pain (1-10) :

What makes your pain better?

What worsens your pain?

Do You Have (Circle): Weakness Numbness Incontinence Balance Problems

What Has Been Tried (Circle): Therapy Injections Other: _____

Did the intervention help? For How Long?

Right handed Left Handed

Medical conditions including surgeries:

List **all** current medications including dosages:

1.
2.
3.
4.
5.
6.

Allergies to medications:

Alcohol Use: Never Occasional Frequent Heavy

Smoking: Never Packs Per Day_____ How Long _____ Yrs

Occupation _____If Not Working, Date Last Worked_____Do You Live Alone? Y N

Family History Of Brain Or Spine Problems? : CIRCLE IF YOU HAVE:

Dizziness	Heart Problems	Chest Pains	Sleep Apnea
Vision Problems	High blood pressure	Breathing Problems	Constipation/Diarrhea
Headache	Diabetes	Arthritis	Erectile dysfunction
Hearing Problems	Fevers	Abdominal Pain	Depression
Fatigue	Recent Weight Loss	Swelling of Legs	Problems with Anesthesia
Nausea/Vomiting	Recent Weight Gain	Frequent Urination	Bleeding Problems