18300 Katy Freeway, Suite 405
Houston, TX 77094

Patient History Form

Name: _____ Date: _____
Last First Middle MM/DD/YEAR

What's the reason for your visit today (when did it start and what are the symptoms)? _____

_____

Do you believe your symptoms are due to an automobile accident or work injury? Yes ___ No ___

Medication(s) (Please list all medication you are currently taking)

Name of Medication:	Dose/Directions:

Drug or other Allergies: _____

Medical History: (Please check all that apply)

	Headache/Migraine		Arrhythmias		Thyroid Disease
	Headache/Tension		Congestive Heart Failure		Menstrual/Sexual Dysfunction
	Epilepsy/Seizures		Myocardial Infarction		Other Endocrine
	Cerebral Vascular		Heart Murmur		Liver Disease/Hepatitis
	Other Neuromuscular		Hypertension		Renal Disease
	Head Injury		COPD		Genitourinary Disease
	Spinal Cord Injury		Asthma		Arthritis
	Cervical Cord Injury		Peptic Ulcer Disease		Cancer
	Peripheral Nerve		Bleeding Disorder		Tuberculosis
	Depression		Anemia		HIV
	Anxiety		Diabetes		Exposures
	Coronary Artery Disease		Peripheral Vascular Disease		Rheumatic Fever
	Other:				

If you checked any of the above, please explain: _____

Family History:

Has anyone else in your family had:

	Cancer		Depression		Epilepsy/Seizures
	Heart Problems		Dementia/Alzeimer's		Neuropathy
	Vascular Disease		Strokes		Muscle Problems
	Diabetes		Parkinson's or Tremors		Brain or Spinal Cord Tumors
	Cholesterol		Migraines		Other

If you checked any of the above, please explain: _____

Social History:

Do you use Tobacco? Yes ____ No ____ If so, how many packs? _____ How often? _____

Do you use Alcohol? Yes ____ No ____ If so, how much? _____ How often? _____

Do you use or ever used recreational drugs? Yes ____ No ____ If so, which drugs? _____