

Cerebral Research, LLC

Past or Present Conditions

General History

- | | |
|----------------------|---|
| Allergies | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Anemia | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Arthritis | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Back Trouble | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Bleeding Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Fatigue | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Gallstones | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Headaches | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Heart Murmur | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Hepatitis | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| High Blood Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Hot Flashes | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Joint Pain | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Kidney Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Migraines | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Night Sweats | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Psychiatric Disorder | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Rheumatic Fever | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Seizures | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Thyroid | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Tuberculosis | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Ulcer | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Weight Loss/Gain | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |

Digestive System

- | | |
|--------------------|---|
| Change in Appetite | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Heartburn | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Nausea | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Vomiting | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Constipation | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Diarrhea | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Hemorrhoids | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |

Genitourinary System

- | | |
|-------------------------|---|
| Frequent Urination | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Urinary Urgency | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Unable to hold Urine | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Pain/Burning with Urine | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |
| Blood in Urine | <input type="checkbox"/> No <input type="checkbox"/> Yes Comment: _____ |

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Nervous System

- Dizziness No Yes Comment: _____
- Fainting No Yes Comment: _____
- Insomnia No Yes Comment: _____
- Memory Loss No Yes Comment: _____
- Poor Coordination No Yes Comment: _____
- Weakness/Paralysis No Yes Comment: _____

Eyes and Nose

- Trouble Seeing No Yes Comment: _____
- Eye Pain No Yes Comment: _____
- Double Vision No Yes Comment: _____
- Farsighted No Yes Comment: _____
- Nearsighted No Yes Comment: _____
- Loss of Smell No Yes Comment: _____
- Obstruction No Yes Comment: _____
- Excess Discharge No Yes Comment: _____
- Nosebleeds No Yes Comment: _____

Cardio-Respiratory

- Persisting Cough No Yes Comment: _____
- Wheezing No Yes Comment: _____
- Chest Pain or Discomfort No Yes Comment: _____
- Pain with Breathing No Yes Comment: _____
- Shortness of Breath No Yes Comment: _____
- Ankle Swelling No Yes Comment: _____
- Pain in Calf No Yes Comment: _____
- Bluish Fingers or Lips No Yes Comment: _____
- Heart Palpitations No Yes Comment: _____
- Irregular Heart Beat No Yes Comment: _____
- Vein Trouble No Yes Comment: _____

Other

Cerebral Research, LLC
Patient Contact Information

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

DOB: ____/____/____ Sex: Female Male Race: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ Phone Number: _____

Employer: _____

Occupation: _____ Work Number: _____

Parent Information

Mother/Legal Guardian

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ DOB: ____/____/____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ Phone Number: _____

Employer: _____

Occupation: _____ Work Number: _____

Parent Information

Father/Legal Guardian

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ DOB: ____/____/____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ Phone Number: _____

Employer: _____

Occupation: _____ Work Number: _____

Emergency Contacts:

Name: _____ Number: _____ Relationship: _____

Name: _____ Number: _____ Relationship: _____