

NEUROSURGICAL ASSOCIATES, P. C.
PATIENT MEDICAL HISTORY

LAST NAME _____ FIRST NAME _____ MI _____ DOB _____ AGE _____

MEDICAL PROBLEM FOR WHICH YOU ARE BEING SEEN _____

IS THIS PROBLEM THE RESULT OF AN ACCIDENT? _____ YES _____ NO IF YES, DATE OF ACCIDENT _____

_____ CAR ACCIDENT _____ WORK ACCIDENT _____ OTHER _____ WHAT IS YOUR PAIN LEVEL ON A SCALE OF 1-10? _____

PRIMARY CARE PHYSICIAN _____ REFERRING PHYSICIAN _____

DO YOU HAVE: HIGH BLOOD PRESSURE? _____ YES _____ NO DIABETES? _____ YES _____ NO

PRIOR MAJOR ILLNESS OR INJURIES _____

PRIOR SURGERIES OR HOSPITALIZATIONS W/ DATE _____

HAVE YOU EVER HAD PROBLEMS WITH ANESTHESIA? _____ NO _____ YES _____

ALLERGIES TO MEDICINES: _____

CURRENT MEDICATIONS (INCLUDING OVER THE COUNTER MEDS, VITAMINS AND SUPPLEMENTS) W/ DOSAGE & HOW OFTEN YOU TAKE THEM

FAMILY HISTORY – LIST ANY **FAMILY MEMBER(S)** AFFECTED BY THE FOLLOWING

DIABETES _____ HEART DISEASE _____

HIGH BLOOD PRESSURE _____ CANCER _____

SPINE PROBLEMS _____ BRAIN TUMOR _____

SOCIAL HISTORY OCCUPATION _____

_____ # CHILDREN _____ SINGLE _____ MARRIED _____ WIDOWED _____ SEPARATED _____ DIVORCED

ALCOHOL USE: _____ I DO NOT DRINK ALCOHOL _____ I USED TO DRINK HOW MUCH/HOW OFTEN _____

_____ I DRINK ALCOHOL HOW MUCH/HOW OFTEN _____

TOBACCO USE: _____ NEVER SMOKED _____ PIPE SMOKER _____ CIGAR SMOKER

_____ FORMER CIGARETTE SMOKER I QUIT _____ YRS AGO, I SMOKED _____ PACKS / DAY FOR _____ YEARS

_____ CURRENT CIGARETTE SMOKER I HAVE SMOKED _____ PACKS / DAY FOR _____ YEARS

ARE YOU AT RISK FOR AIDS? (BLOOD TRANSFUSION, NEEDLE STICK, IV DRUG USE, SEXUAL ORIENTATION) _____ YES _____ NO

(OVER)

REVIEW OF SYSTEMS

PLEASE CHECK IF YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING:

EYES

- CATARACTS
- GLAUCOMA
- INFECTIONS
- INJURIES
- WEAR GLASSES/CONTACTS

EAR, NOSE, THROAT

- BALANCE DISTURBANCE
- EAR INFECTIONS
- EAR PAIN
- HEARING LOSS
- INABILITY TO SMELL
- MOUTH SORES
- NASAL CONGESTION
- NASAL DRAINAGE
- RINGING IN EARS
- SINUS HEADACHES
- SINUS PROBLEMS
- SORE THROATS
- WEAR HEARING AIDS

CARDIOVASCULAR

- CHEST PAIN
- HEART DISEASE
- HEART MURMUR
- HIGH CHOLESTEROL
- HYPERTENSION
- IRREGULAR HEARTBEAT
- SWELLING OF HANDS OR FEET

RESPIRATORY

- ASTHMA
- BRONCHITIS
- BLOODY SPUTUM
- BRONCHITIS
- CHRONIC COUGH
- EMPHYSEMA
- LUNG CANCER
- PNEUMONIA
- SHORTNESS OF BREATH

GASTROINTESTINAL

- ABDOMINAL PAIN
- BLOOD IN STOOL
- BLOOD IN VOMIT
- CHANGE IN BOWEL HABITS
- COLON CANCER
- HEPATITIS
- INDIGESTION
- JAUNDICE
- LIVER DISEASE
- NAUSEA
- ULCERS OR GASTRITIS

GENITOURINARY

- BLOOD IN URINE
- CERVICAL CANCER
- DIFFICULTY URINATING
- ENDOMETRIOSIS
- INCONTINENCE
- KIDNEY DISEASE
- KIDNEY STONES
- OVARIAN CANCER
- PAINFUL URINATION
- PROSTATE CANCER
- URINARY TRACT INFECTIONS
- UTERINE CANCER

INTEGUMENTARY

- BREAST CANCER
- BREAST PAIN OR TENDERNESS
- NIPPLE DISCHARGE
- SKIN DISEASE
- SKIN CANCER

ALLERGY/IMMUNOLOGY

- FOOD ALLERGIES
- NASAL ALLERGIES
- IMMUNE DISORDERS

PSYCHIATRIC

- ANXIETY
- DEPRESSION
- OTHER

CONSTITUTIONAL

- EXCESSIVE FATIGUE
- FEVER
- NIGHT SWEATS
- WEIGHT LOSS

NEUROLOGICAL

- COORDINATION IN ARMS
- COORDINATION IN LEGS
- DISORIENTATION
- FACIAL WEAKNESS
- FAINTING
- INABILITY TO CONCENTRATE
- MEMORY PROBLEMS
- MIGRAINES
- SEIZURES
- SPEECH DIFFICULTIES
- STROKE

ENDOCRINE

- DIABETES
- EXCESSIVE THIRST OR URINATION
- HORMONE PROBLEMS
- INCREASED APPETITE
- THYROID DISEASE

HEMATOLOGY/LYMPHATIC

- ANEMIA
- BLEEDING TENDENCIES
- BLOOD TRANSFUSION (DATE _____)
- HEMOPHILIA
- SWOLLEN GLANDS/NODES

MUSCULOSKELETAL

- ARM NUMBNESS (L OR R)
- ARM PAIN (L OR R)
- ARM WEAKNESS (L OR R)
- ARTHRITIS
- BACK PAIN
- GOUT
- JOINT PAIN
- JOINT SWELLING
- LEG NUMBNESS (L OR R)
- LEG PAIN (L OR R)
- LEG WEAKNESS (L OR R)
- NECK PAIN

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE

PATIENT SIGNATURE _____ DATE _____

PRINT NAME _____

PHYSICIAN SIGNATURE _____ DATE _____

