



NEUROSURGERY PATIENT HISTORY FORM

Name: _____ Age: _____ Date: _____

Family Doctor/Internist:			Who referred you to us?		
Name: _____			Name: _____		
Address: _____			Address: _____		
City, State, Zip: _____			City, State, Zip: _____		
Send them a letter?	Yes	No	Send them a letter?	Yes	No

Are you employed? Yes No Occupation: _____
 Are you married? Yes No Number of Children: _____ Ages: _____

Check all that apply:

- Injury on the job Auto accident injury
 Receiving disability income Legal proceedings pending
 Receiving worker's comp. Working with a rehab nurse

Does this problem keep you from working? Yes No (If yes, date last worked: _____)

Describe the onset on your problem: _____ Date of onset: _____

Have you ever had any of the following:

	Yes	No			
An exam by a cardiologist (heart doctor)			If yes, Dr's Name	City	Year
Heart Catheterization			If yes, where		Year
Exercise Stress Test			If yes, where		Year
Ultrasound of Heart (Echocardiogram)			If yes, where		Year
Pacemaker			If, yes, Dr.'s Name	City	Year

Have you taken any Aspirin or Aspirin-like product (Motrin, Advil, Nuprin) in the last 10 days? Yes No
 If yes, what medication did you take? _____ When? _____

Please list all previous hospitalizations (surgery, childbirth, medical illness):

Date (approx. year)	Reason	Place
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Reviewed with Patient:
 Physician Signature: _____ Date: _____

MEDICAL HISTORY REVIEW

NAME: _____ AGE: _____ DATE: _____

HEIGHT: _____ WEIGHT: _____

Allergies to medications (list all): _____

Current Medications (list medication, dosage and how often you take it): _____

Review of systems (check all that apply):

CONSTITUTIONAL:

- _____ weight gain
- _____ weight loss
- _____ fever
- _____ chills
- _____ sexual dysfunction

GASTROINTESTINAL:

- ___ abdominal pain
- ___ diarrhea
- ___ constipation
- ___ bowel incontinence

SKIN:

- _____ cancer
- _____ skin

EYES:

- _____ vision sharp
- _____ blurred vision
- _____ double vision

URINARY:

- ___ difficulty urinating
- ___ urinary incontinence
- ___ urgency

ALLERGY:

- _____ seasonal
- _____ tape
- _____ food
- _____ animals
- _____ dust
- _____ other

HEAD/EARS/NOSE/THROAT:

- _____ headache
- _____ nasal drainage
- _____ hearing loss

NEUROLOGICAL:

- ___ seizure
- ___ memory

CARDIOVASCULAR/RESPIRATORY:

- _____ chest pain (angina)
- _____ palpitations
- _____ heart arrhythmia
- _____ shortness of breath

PSYCHIATRIC:

- ___ depression
- ___ manic depression
- ___ other

OTHER PROBLEMS WE SHOULD BE AWARE OF: _____

Past medical history:

YOU:		Family:		bleeding problem	other medical conditions:
					YOU: _____
	heart attack			stress test	_____
	heart failure			cancer	_____
	high blood pressure			hepatitis	Family: _____
	stroke			pulmonary embolus	_____
	kidney disease			blood clotting	_____
	heart catheterization			diabetes	_____

Do you smoke? ___yes ___no (# packs/day: ___ for ___ years ___ Other forms of tobacco: _____)

Do you drink? ___yes ___no (number of drink/week _____)

Patient Signature:

Date:
