Neurosurgery Associates

Patient Name:_____Age_____Date of Birth:_____

Chief Complaint:_____

HT:_____ WT:_____ ☐ Right Handed ☐ Left Handed

Referring /Primary Physician _____

Current Medication:

Medication Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies to Medication:

_____ _____

_____ _____

Past Medical History

Y N Autoimmune Disorder
Y N Blood Transfusion – Date_____
Y N Colon Cancer
Y N Depression
Y N Diabetes Type 1
Y N Diabetes Type 2
Y N Blood Clots – DVT – Date_____
Y N Hepatitis B

Check all Medical conditions you have

Y N Hepatitis C
Y N Hypertension
Y N Thyroid Disease
Y N Liver Disease
Y N Osteoarthritis
Y N Stroke – CVA
Y N Seizure Disorder
☐ Other_____

Past Surgical History

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

Family Medical History

Family Member	Alive/Deceased	Age	Health Status Or Cause Of Death
Mother			
Father			
Sibling			
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Mathernal Grandfather			

Social History: Check all that apply

Marital Status _____Married _____Single ____Divorced _____Widowed

Children: _____Yes, How Many_____ _____No

Smoker _____Yes, How Many Pack/Day_____ _____Former Quit/When _____ Never_____

Alcohol _____Yes, How Much_____ _____No

Review of Systems:

Constitutional
Y N Chest Pain
Y N Excessive Fatigue
Y N Fever
Y N Weight Loss

EENT Ears Nose Throat
Y N Double Vision(diplopia)
Y N Drainage from ears
Y N Drainage from eyes
Y N Hearing loss
Y N Inability to smell
Y N Vision changes

Cardiovascular /Respiratory
Y N Chest Pain
Y N Chronic cough
Y N Difficulty breathing lying down (orthopnea)
Y N Palpitations
Y N Swelling in hands or feet (peripheral edema)
Y N Shortness of breath
Y N Fainting (Syncope)
Y N Wheezing

Endo/Gastrointestinal
Y N Abdominal pain
Y N Bowel incontinence
Y N Difficulty swallowing (dysphagia)
Y N Heartburn/indigestion
Y N Yellow Skin (jaundice)
Y N Nausea
Y N Painful swallowing (Odynophagia)
Y N Vomiting

Genitourinary
Y N Painful urination (dysuria)
Y N Blood in urine (hematuria)
Y N Incontinence urinary
Y N Sexual dysfunction

Musculoskeletal
Y N Extremity pain
Y N Extremity weakness
Y N Joint Pain
Y N Muscle weakness
Y N Poor range of motion
Y N Restless leg

Neuro/Psych
Y N Anxiety
Y N Balance problems
Y N Black outs
Y N Depression
Y N Frequent falls
Y N Frequent headaches
Y N Inability to concentrate
Y N Speech difficulty
Y N Walking difficulty
Y N Vertigo

Derm/Allergy
Y N Abnormal bruising
Y N Bleeding
Y N Rash
Y N Recurrent infection

The Above Information is accurate to the best of my knowledge.

Patient Signature _____ **Date_____**

Physician Signature_____ **Date_____**