Neurosurgical Medical Clinic, Inc.

Patient History Form

Dear Patient:

Thank you for choosing the Neurosurgical Medical Clinic, Inc. for your neurosurgical healthcare needs. Your time and health concerns are very important to us. We certainly appreciate your trust and confidence in us, and we will do our best to meet all of your expectations.

Listed below are a few questions that will help us provide you with best medical care possible. Please answer as many of the questions as you can, as completely possible. If you do not understand one or more of the questions, or are uncomfortable answering one or more of the questions, please leave those questions blank. This information will be kept only as a confidential part of your medical record and is used solely for the purpose of providing you with the best medical care possible. We appreciate your help and cooperation in this regard.

Date: _____ / _____ / _____

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

Date of Birth: _____

Describe is as much detail as possible the reason you are here today:

_____

_____

I write with my ☐ Right ☐ Left hand (check one)

Brain Tumor ☐

Neck pain ☐ Arm Pain ☐ Low back pain ☐ Leg pain ☐ Face Pain ☐

If having pain which side? ☐ Right Side ☐ Left Side ☐ Bilateral (check one)

Neurosurgical Medical Clinic, Inc.

NAME: _____ Date: ____ / ____ / ____

PAST MEDICAL HISTORY

Have you ever been told that you had any of the following (please check and give date)?

Head and Neck **Date**

- ☐ Glaucoma _____
- ☐ Sinusitis _____
- ☐ TMJ syndrome _____

Lungs

- ☐ asthma _____
- ☐ emphysema _____
- ☐ bronchitis _____
- ☐ pneumonia _____
- ☐ tuberculosis _____

Heart

- ☐ heart failure _____
- ☐ heart attack _____
- ☐ high blood pressure _____
- ☐ heart murmur _____
- ☐ abnormal heartbeat _____
- ☐ vascular disease _____

Abdomen

- ☐ ulcer _____
- ☐ liver disease _____
- ☐ colitis _____
- ☐ pancreatitis _____
- ☐ diverticulitis _____
- ☐ inflammatory bowel _____
- ☐ hernia _____
- ☐ hemorrhoids _____

Genitourinary

- ☐ bladder infection _____
- ☐ kidney stone _____
- ☐ prostate disease _____
- ☐ venereal disease _____
- ☐ herpes _____
- ☐ impotence _____
- ☐ orchitis _____
- ☐ pelvic infection _____

Endocrine **Date**

- ☐ thyroid disease _____
- ☐ parathyroid disease _____
- ☐ diabetes _____
- ☐ pituitary disease _____
- ☐ adrenal disease _____

Other

- ☐ anemia _____
- ☐ cancer _____
- ☐ easy bleeding _____
- ☐ eczema _____
- ☐ psoriasis _____

Rheumatic/back

- ☐ gout _____
- ☐ osteoporosis _____
- ☐ osteoarthritis _____
- ☐ rheumatoid arthritis _____
- ☐ spinal disc disease _____
- ☐ radiculopathy _____
- ☐ scoliosis _____
- ☐ sciaticia _____
- ☐ pars defect _____
- ☐ claudication _____
- ☐ multiple sclerosis _____
- ☐ muscular dystrophy _____

Vertebral Fracture

- ☐ ankylosing spondylitis _____
- ☐ spinal stenosis _____
- ☐ synringomyelia _____
- ☐ spina bifida _____
- ☐ spondylolithesis _____
- ☐ Reiter's syndrome _____

Neurologic/Psychiatric

- ☐ stroke _____
- ☐ seizure _____
- ☐ depression _____
- ☐ eating/mood disorder _____

Neurosurgical Medical Clinic, Inc.

NAME: _____ Date: ____ / ____ / ____

PAST MEDICAL HISTORY (continued)

In the space provided below please list all operations you have had in the past and the year in which the operation took place.

Operation	**Year**
Example: Appendectomy	*Example: 1988*

Please list all other medical problems for which you have been hospitalized in the past.

Medical Illness	**Year**
Example: Heart Attack	*Example: 1988*

MEDICATIONS

Please list all medications that you are currently taking, including those prescribed by other physicians or those purchased over-the-counter at a drugstore. Include the pill size, if you know this information, and the number of pills you take and the number of times during the day you take this many pills.

Medication	**Reason for taking medication**	**Pill Size**	**Number of Pills Taken at One Time**	**Number of Pills taken Each Day**
Example: Motrin		*Example: 200mg*	*Example:1-4*	*Example: 4 times a day*

Please provide the name and telephone number of your pharmacy:

Name: _____ Phone: (_____) _____ - _____

Neurosurgical Medical Clinic, Inc.

NAME: _____ Date: ____ / ____ / ____

ALLERGIES

Please list below all drugs you have allergic reactions to along with the type of reaction.

Drug	**Reaction**
Example: Aspirin	*Example: Hives*

FAMILY MEDICAL HISTORY

Is there any history of cancer in you family? Yes ☐ No ☐

If yes, please describe _____

Is there any history of heart disease in your family? Yes ☐ No ☐

If yes, please describe _____

Is there any history of diabetes in your family? Yes ☐ No ☐

If yes, please describe _____

If living, please indicate age and medical problems. If deceased, please give age at death and cause.

Father _____ Mother _____

Brother/Sister _____

Children _____

Any medical problems that you feel run in your family? _____

_____

Neurosurgical Medical Clinic, Inc.

NAME: _____ Date: ____ / ____ / ____

SOCIAL HISTORY

Marital Status Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

Where were you born? _____

In what city do you live? _____

What was the highest level of formal education you received? _____

Did you serve in the military, if so which branch and when? _____

Present occupation? _____ How many years in occupation? _____

How many glasses of alcohol per week do you drink? _____

How many packs of cigarettes per day do you smoke? _____

What recreational drugs do you use? _____

How many cups, per day, do you have of coffee _____ tea _____ soda _____

What are your hobbies and which sports do you play? _____

Are there any relationships with family or friends, now or in the past, which are very difficult or abusive? _____

Because of possible additional testing, please answer the following questions:

Are you pregnant? Yes ☐ No ☐

Do you have brain clips? Yes ☐ No ☐

Do you wear a hearing aid? Yes ☐ No ☐

Do you have metal in your body? Yes ☐ No ☐

Do you have a pacemaker? Yes ☐ No ☐

Do you experience claustrophobia? Yes ☐ No ☐

Weight: _____ Height: _____

Neurosurgical Medical Clinic, Inc.

NAME: _____ Date: ____ / ____ / ____

REVIEW OF SYSTEMS

Are you **currently** bothered by any of the following (please check)?

General
- ☐ fever
- ☐ sweats
- ☐ weight change
- ☐ appetite change
- ☐ fatigue

Skin
- ☐ itching
- ☐ pigmentation change
- ☐ hair or nail problem
- ☐ warts

Head
- ☐ headache
- ☐ dizzy spells
- ☐ fainting
- ☐ poor vision
- ☐ water/itchy eyes
- ☐ ringing in the ears
- ☐ ear pain
- ☐ poor hearing

Respiratory
- ☐ loss of smell
- ☐ sinus pain
- ☐ nose bleed
- ☐ runny nose
- ☐ sore throat
- ☐ cough
- ☐ sputum
- ☐ wheezing

Hematological
- ☐ easy bruising
- ☐ swollen lymph nodes

Cardiovascular
- ☐ chest pain
- ☐ unable to breathe with walking
- ☐ waking at night short of breath
- ☐ palpitations
- ☐ ankle swelling
- ☐ calf cramping with walking

Genitourinary
- ☐ urinate at night
- ☐ pain on urination
- ☐ blood in urine
- ☐ incontinence
- ☐ vaginal pain

Musculoskeltal
- ☐ muscle pain
- ☐ joint pain
- ☐ joint swelling
- ☐ back pain

Abdomen
- ☐ trouble swallowing
- ☐ nausea/vomiting
- ☐ stomach pain
- ☐ heartburn
- ☐ constipation
- ☐ diarrhea
- ☐ blood in the stool
- ☐ black stool

Neurologic
- ☐ weakness
- ☐ numbness
- ☐ poor coordination
- ☐ difficulty speaking
- ☐ poor memory
- ☐ tremor
- ☐ depression
- ☐ anxiety

Sleep
- ☐ poor sleep patterns
- ☐ daytime sleepiness

Endocrine
- ☐ hot/cold intolerance
- ☐ excessive thirst/urination
- ☐ excessive facial/body hair

Other (not listed): _____