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 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 any of the questions, or are uncomfortable answering 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: _____ **Weight:** _____**Height**:_____

Language: ☐ English ☐ Spanish ☐ Patient declines ☐ Other:_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Unknown ☐ Decline

☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander

Describe in as much detail why you are being seen today: _____

_____

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

☐ Face Pain ☐ Brain Tumor ☐ Neck pain

☐ Arm Pain ☐ Low back pain ☐ Leg Pain

If having pain which side? ☐ Right Side ☐ Left Side ☐ Bilateral

Fall Screening: ☐ No Falls in the past year ☐ One Fall without Injury in the past year

☐ Two or more Falls in the Past year ☐ At least one fall with injury in the past year

Patient Name: _____Date of Birth:_____

PAST MEDICAL HISTORY

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: (_____) _____ - _____

Patient Name: _____Date of Birth:_____

ALLERGIES

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

Allergy	**Reaction**
Example: Aspirin	*Example: Hives*

FAMILY MEDICAL HISTORY

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

If yes please describe: _____

Is there any history of heat 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:_____

SOCIAL HISTORY

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

Do you drink alcohol? ☐ Yes ☐ No **If yes, how many drinks per week?** _____

Are you a current smoker: ☐ Yes ☐ No ☐ Former

If yes, how many packs per day? _____ **If a former smoker, year quit:** _____

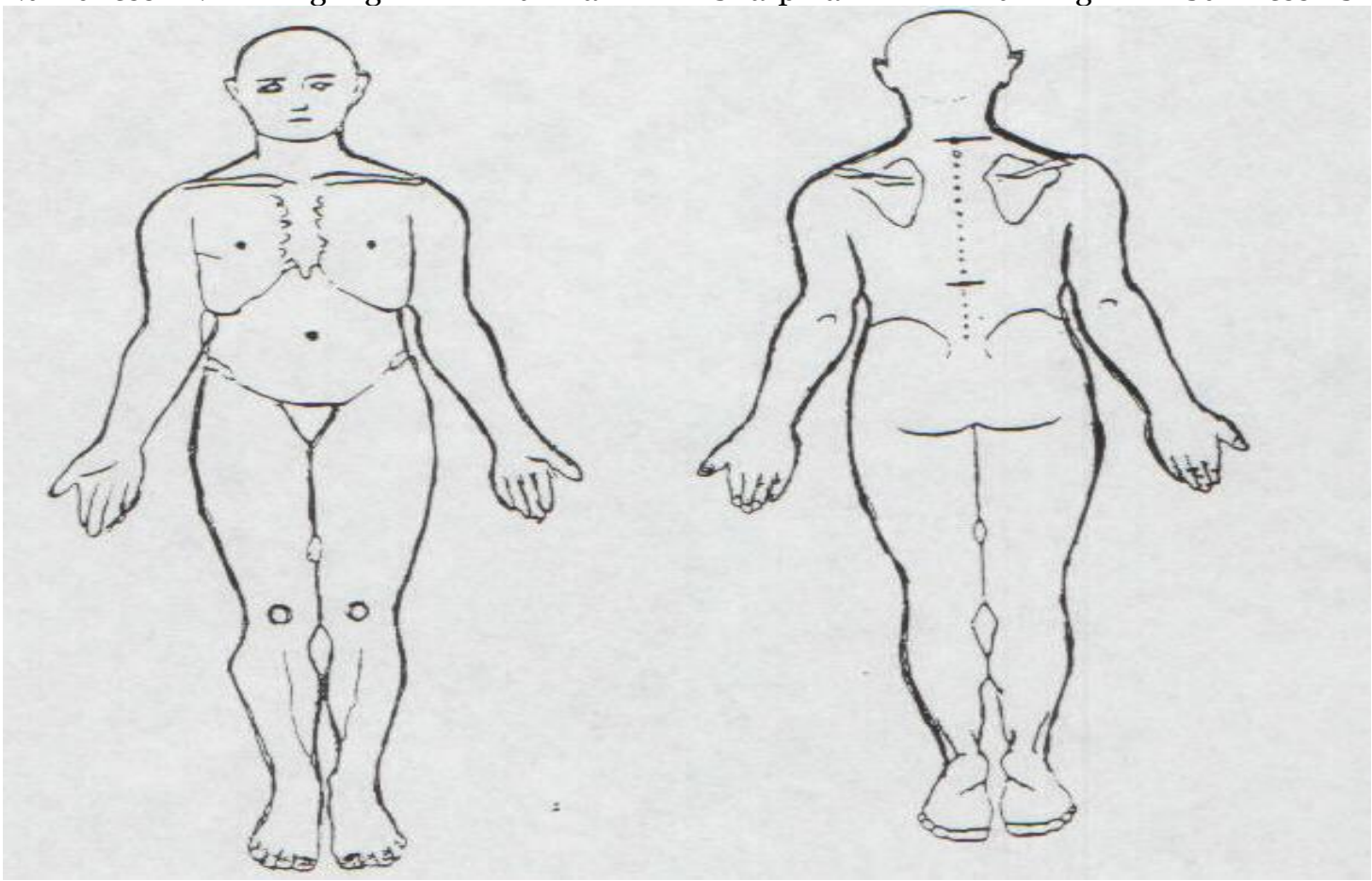
Patient Name: _____Date of Birth:_____

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

On the drawings below, please indicate where you are experiencing pain by drawing the letter abbreviations on the diagrams that most accurately reflect the type of discomfort that you have been experiencing.

Numbness =N Tingling =T Dull Pain = D Sharp Pain = P Burning = B Stiffness =S



Patient Name: _____Date of Birth:_____

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

Musculoskeletal:
- ☐ muscle pain
- ☐ joint pain
- ☐ joint swelling
- ☐ back pain
- ☐ neck 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):_____