Neurosurgery Associates

An Affiliate of St. Dominic Medical Associates

NAME: _____

DATE: _____

MEDICAL HISTORY

Please check any symptoms you have experienced recently.

HEENT:

Dizziness or vertigo	Yes _____	No _____
Headaches	Yes _____	No _____
Visual Problems	Yes _____	No _____
Wear Glasses	Yes _____	No _____
Problems with ears	Yes _____	No _____
Hayfever/sinus	Yes _____	No _____
Fainting spells	Yes _____	No _____
Thyroid disease	Yes _____	No _____

PULMONARY:

Cough	Yes _____	No _____
Coughing up blood	Yes _____	No _____
Shortness of breath	Yes _____	No _____
Night Sweats	Yes _____	No _____
Asthma	Yes _____	No _____
Pneumonia	Yes _____	No _____
Tuberculosis	Yes _____	No _____

CARDIAC:

Chest pain or angina	Yes _____	No _____
History of "heart trouble"	Yes _____	No _____
Awake short of breath	Yes _____	No _____
Sleep on multiple pillows	Yes _____	No _____
Palpitations/heart flutters	Yes _____	No _____
High blood pressure	Yes _____	No _____
Swelling hands or feet	Yes _____	No _____
"Black out" spells	Yes _____	No _____
Heart murmurs	Yes _____	No _____
Shortness of breath with Exertion	Yes _____	No _____
Heart murmurs	Yes _____	No _____

GASTROINTESTINAL:

Appetite Good _____ Fair _____ Poor _____

Nausea or vomiting	Yes _____	No _____
Indigestion or heartburn	Yes _____	No _____
Intolerance of some foods	Yes _____	No _____
Recent weight loss or gain	Yes _____	No _____
Diarrhea	Yes _____	No _____
Constipation	Yes _____	No _____
Hemorrhoids	Yes _____	No _____
Blood in bowel movement	Yes _____	No _____
Black-or tarry stools	Yes _____	No _____

GENITO-URINARY:

Pain on urinating	Yes _____	No _____
Difficulty starting urine	Yes _____	No _____
Do you get up at night to urinate	Yes _____	No _____
How many times	1-2 _____	3-4 _____ More _____
Any blood in urine	Yes _____	No _____
Lose urine coughing	Yes _____	No _____
Hernia	Yes _____	No _____
History of kidney stones	Yes _____	No _____

EXTREMITIES:

Joint pains or sitting	Yes _____	No _____
Swelling of any joints	Yes _____	No _____
Tingling, weakness, or numbness of hands	Yes _____	No _____
Leg cramps with walking	Yes _____	No _____
Enlarged veins in legs	Yes _____	No _____

NEUROPSYCHIATRIC:

Difficulty in sleeping	Yes _____	No _____
Nervous disorder	Yes _____	No _____
Seizure disorder	Yes _____	No _____
Anxiety	Yes _____	No _____
Depression	Yes _____	No _____
Nightmares	Yes _____	No _____

BREAST:

Swelling or pain	Yes _____	No _____
Discharge from nipple	Yes _____	No _____
History of breast cancer in family	Yes _____	No _____
Breast nodules/cysts	Yes _____	No _____

HEMATOLOGICAL:

Excessive bleeding following cuts or dental work	Yes _____	No _____
Easy bruising	Yes _____	No _____

PREGNANCIES:

How many children born alive: _____

Any complications with pregnancy? _____

Other medical problems: _____

_____

_____

NAME: _____

DATE: _____

PATIENT QUESTIONNAIRE

Please check any symptoms you have experienced recently.

Name (Last, First, MI): _____ **Date of Birth:** _____

Referring Physician: _____ **Phone Number:** _____

Family Physician: _____ **Phone Number:** _____

Other treating physicians: _____ **Phone Number:** _____

Medical Problems (such as heart, lungs, kidney disease, diabetes, high blood pressure, arthritis, stroke, etc):

_____

Past Injuries: _____

Past Surgeries: _____

Medications: _____

Drug Allergies: _____

Social History:

Do you smoke? Yes _____ **No** _____ **If so, how much?** _____

Do you drink: Yes _____ **No** _____ **If so, how much?** _____

Have you used any recreational drugs in the past year? (Circle all that apply)

Cocaine Marijuana Heroin amphetamines Other: _____

Work History:

Employer: _____ **Length of employment:** _____

Job description: _____ **Were you injured at work? Yes** _____ **No** _____

Are you presently involved in a lawsuit or workman's compensation? (If so, please explain):

_____

_____

Present Illness:

Describe the problem which brings you here: _____

_____

What is your average pain level per month?

No problem 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

What makes it better? _____ **Worse?** _____

		WHEN?		WHEN?
What tests have you had done?	**MRI**	_____	**X-Rays**	_____
	CT Scan	_____	**EMG/NCV**	_____
	Myelogram	_____	**Bone Scan**	_____