NEUROSURGERY SPECIALISTS HISTORY FORM ACCT # _____

_____ _____ _____ _____
First Name Last Name M.I. Date of Birth

CHECK ALL THAT APPLY:

☐ Injury on the job Date_____ Receiving Disability Income? _____

☐ Auto Accident Date_____ Receiving Workers Comp Payments?_____

Working with a Case Manager or Rehab Nurse?_____

Are you employed?_____ Date Last Worked_____

Occupation_____

Does this problem keep you from working?_____ Are you: ☐ Right handed or ☐ Left handed

REASON FOR VISIT (Chief Complaint):_____

_____

_____ Date of Onset_____

CHECK ALL TREATMENTS THAT HAVE BEEN TRIED TO HELP YOU:

☐ Physical Therapy ☐ Massage ☐ Heat ☐ Ultrasound ☐ Bed rest

☐ Traction ☐ Cortisone shots ☐ Exercise ☐ Other (specify)_____

☐ None of the above

PLEASE LIST ALL CURRENT MEDICATIONS, SUPPLEMENTS, VITAMINS AND HERBS YOU ARE TAKING
(or provide a list for us to copy):

Medication	Dose	How many time daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES TO MEDICATIONS, TAPE OR LATEX? PLEASE LIST:

_____

_____

MEDICAL PROBLEMS YOU ARE BEING TREATED FOR (such as High Blood Pressure, Diabetes, Osteoporosis, Stroke, Cancer, Other):_____

_____

_____

LIST ALL PAST SURGERIES (include dates, if known):_____

_____

_____

First Name	Last Name	M.I.	Date of Birth
_____	_____	_____	_____

REVIEW OF SYSTEMS (Please check all that apply to your health history):

GENERAL

☐ Difficulty Sleeping ☐ Depression ☐ Fever over 100F ☐ Generalized Weakness
☐ Weight Loss Over 10lb in One Year ☐ Swollen Lymph Nodes

NEUROLOGIC

☐ Chronic Headaches ☐ Blackouts ☐ Seizures ☐ Loss of Balance/Coordination
☐ Arm Numbness or Weakness ☐ Leg Numbness or Weakness

MUSCULAR/SKELETAL

☐ Severe Pain/Stiffness in Joints ☐ Pain/Stiffness or Weakness in Muscles

GASTROINTESTINAL

☐ Loss of Appetite ☐ Weight Loss or Gain ☐ Frequent Indigestion
☐ Frequent Nausea/Vomiting ☐ Change in Bowel Habits ☐ Frequent Diarrhea or Constipation
☐ Ulcers ☐ Gallbladder Problems ☐ Excessive Thirst

RESPIRATORY

☐ Chronic Cough ☐ Shortness of Breath ☐ Coughing Up Blood

HEART

☐ Palpitations ☐ Heart Murmur ☐ Chest Pain ☐ Irregular Heart Rate
☐ Ankle Swelling ☐ Shortness of Breath

GENITOURINARY

☐ Difficulty with Urination ☐ Sexual Dysfunction ☐ Blood in Urine ☐ Frequent Urination
☐ Frequent Bladder Infections ☐ Loss of Urine Unintentionally

HEENT

☐ Loss of Hearing ☐ Chronic Headaches ☐ Dizziness ☐ Ringing in Ears
☐ Double Vision ☐ Reduced Field of Vision ☐ Lost Sense of Smell ☐ Difficulty Swallowing
☐ Frequent Choking on Foods/Fluids ☐ Frequent Nose Bleeds

HEMATOLOGIC

☐ Bruises Easily ☐ Bleeds Easily When Cut

OTHER NOT LISTED:_____

First Name	Last Name	M.I.	Date of Birth
_____	_____	_____	_____

SOCIAL HISTORY

Are you married?_____

Do you smoke _____ # of packs_____ for_____ years

Do you use other forms of tobacco?_____ Drug abuse?_____

Do you drink alcohol?_____ # of drinks weekly_____

FAMILY HISTORY

Mother: Living or Deceased _____ Age _____ Cause if deceased _____

Father: Living or Deceased _____ Age _____ Cause if deceased _____

Brother: Living or Deceased _____ Age _____ Cause if Deceased _____

Brother: Living or Deceased _____ Age _____ Cause if Deceased _____

Sister: Living or Deceased _____ Age _____ Cause if Deceased _____

Sister: Living or Deceased _____ Age _____ Cause if Deceased _____

Other: Living or Deceased _____ Age _____ Cause if Deceased _____

Have either of your parents or siblings had any of the following (Use M, F, B, S):

_____Heart Disease

_____High Blood Pressure

_____Mental Or Emotional Problems

_____Epilepsy or other Nervous System Problems

_____Kidney Disease

_____Muscle Disease

_____Stroke

_____Cancer