NEUROSURGERY PATIENT HISTORY

Today's Date___/___/___ **Name** _____ **Date of Birth**___/___/___

Primary Physician: _____ **Doctor's phone#** _____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe problem in detail)

_____

_____

_____

History of Present Illness

Please answer the following questions

Location of the problem?
Head Neck Back Legs
Arms/shoulders
Other _____
_____
_____

On a scale of 1 - 10 with 10 being the most severe, circle the number that best describes the severity of your problem
1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago
Other _____

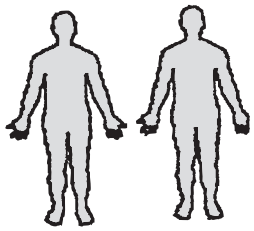
Do you think the problem is related to an accident, injury, or other cause?
YES NO If yes, please explain _____
_____

Does anything help or make the problem worse? ("H" for helps or "W" for worse, leave blank if no effect)
Moving around_____ Standing_____ Bending_____
Sneeze/cough_____ Sitting_____ Walking_____
Lying Down_____ Medications_____
Other _____

Does the problem interfere with your normal functions? Yes No If yes, explain

Indicate location of pain or numbness on the diagram.

Front Back



"X" for pain areas
"O" for numb areas

Have you had treatment for your problem?
Yes No If Yes, please indicate treatment:
physical therapy chiropractic
surgery injections medications_____
Other_____

How long does the problem last?
5 minutes hours always present
Other_____

Is anything else occurring at the same time?
Yes No If yes, please explain
Numbness?
Pins and needles sensation?
Weakness?
Other_____

Is the problem consistant or variable?
Dull then sharp Aching Always there
Shooting or stabbing Other

Physician use only (Notes)

HISTORY-PAST MEDICAL, SOCIAL, FAMILY

List medications you are currently taking_____
Medicine / dosage_____
_____
_____
_____
_____
_____

Do you have any allergies to medicines?
Yes No If yes, please list medicine and your reaction (rash, stomach upset, breathing problems, etc.)
_____
_____
_____

Medical illnesses/problems (examples: diabetes, high blood pressure, heart disease, cancer, depression, etc.)
_____
_____

List previous operations:_____
_____
_____

Family History: (circle as appropriate, list others)
heart disease stroke aneurysm
cancer bleeding problems tuberculosis
major complication from anesthesia
Other _____

Marital status:_____ # of children_____

What is your occupation? _____

Habits:
Do you smoke? Yes No
If yes, how much? _____

Do you drink alcohol? Yes No
If yes, how much? _____

Do you use herbal medicines? Yes No
If yes, please list: _____
_____

Review of Systems

Do you now or have you had problems related to the following systems? Circle Yes or No.
Please explain Yes answers in margin

Constitutional Symptoms
Fever Y N
Weight loss Y N
Headache Y N
Other _____

Eyes
Blurred vision Y N
Double vision Y N
Pain Y N
Other _____

Allergic/Immunologic
Hay fever Y N
Asthma Y N
Other _____

Neurologic
Tremors Y N
Seizure Y N
Numbness Y N
Other _____

Endocrine
Severe thirst Y N
Too hot/cold Y N
Sluggish Y N
Other _____

Gastrointestinal
Nausea Y N
Vomiting Y N
Loss of Bowel Control Y N
Ulcers/Bleeding Y N
Other _____

Cardiovascular
Chest pain Y N
High BP Y N
Other _____

Integumentary
Skin rash Y N
Persistent itch Y N
Boils Y N
Other _____

Musculoskeletal
Joint pain Y N
Broken Bones Y N
Arthritis Y N
Weakness Y N
Other _____

Ear/Nose/Throat/Mouth
Sore Throat Y N
Sinus Problems Y N
Ringing in Ears Y N
Other _____

Genitourinary
Kidney Problems Y N
Painful Urination Y N
Loss of Bladder Control Y N
Other _____

Psychologic
Are you Depressed Y N
Are you Anxious Y N
Considered Suicide Y N
Other _____

Respiratory
Wheezing Y N
Frequent Cough Y N
Emphysema Y N
Shortness of Breath Y N
Other _____

Hematologic/Lymphatic
Swollen Glands Y N
Blood Clotting Trouble Y N
Easy Bruising/Bleeding Y N
Other _____

Physician Use Only:

Physician_____
Date_____/_____/_____