



NEUROSURGERY NEW PATIENT HISTORY

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Age: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Are you right or left-handed? \_\_\_\_\_

What type of problem are you currently having? (circle all that apply)

Neck

Arm

Lower Back

Upper Back

Leg (Right, Left, or Both)

Other (explain): \_\_\_\_\_

How & when did this problem begin? \_\_\_\_\_

Have you been treated for this problem in the past? \_\_\_\_\_

If yes, when? \_\_\_\_\_ If yes, treating physician: \_\_\_\_\_

Have you ever been injured in the past? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

PERSONAL HISTORY

Please answer Yes or No regarding the following medical problems. IF YES, please give the year the problem was diagnosed.

- High Blood Pressure [ ] Yes [ ] No
Heart Problems [ ] Yes [ ] No
Lung Problems [ ] Yes [ ] No
Kidney Problems [ ] Yes [ ] No
Hepatitis [ ] Yes [ ] No
Diabetes [ ] Yes [ ] No
Cancer or Other Tumors [ ] Yes [ ] No
Stomach Ulcers [ ] Yes [ ] No
Other Medical Problems [ ] Yes [ ] No

Please list any surgeries you have had and what year: \_\_\_\_\_

List the medications you take at the present time and the doctor who prescribed them: \_\_\_\_\_

List all medications to which you are allergic: \_\_\_\_\_

Are you allergic to seafood? \_\_\_\_\_ Are you allergic to latex? \_\_\_\_\_

Marital Status: (Circle One)      Single      Married      Separated      Divorced      Widowed

Are you currently working? \_\_\_\_\_ If not, last date worked? \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Job Description: \_\_\_\_\_

How long at this job: \_\_\_\_\_

Circle last grade you completed in school: 1 2 3 4 5 6 7 8 9 10 11 12

College level completed: 1 2 3 4 Degree \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If yes, how many packs per day? \_\_\_\_\_ For how long? \_\_\_\_\_

If you used to smoke and have quit, when did you quit? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If yes, how often? \_\_\_\_\_

### FAMILY HISTORY

Is there any family history of the following?

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spine Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alzheimer's	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Brain Tumor	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Aneurysm	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### NEUROLOGICAL REVIEW

Are you currently having any of the following? (Please check all that apply)

- Loss of vision, double or blurred vision
- Vertigo or dizziness
- Loss of hearing or ringing in your ears
- Paralysis or weakness
- Loss of smell or unusual smells
- Numbness or loss of sensation
- Syncope or passing out spells
- Memory problems
- Convulsions, seizures or fits
- Personality changes
- Severe headaches
- Loss of control of bladder or bowels

