Neurosurgical Associates, LTD

Health History Form

What is your height? ☐

What is your weight? ☐

Hand Preference ☐R ☐L ☐B

Patient Name:

Birth Date: **Gender:**

Appt Date: **MRN:**

Staff to complete

BP ☐

BMI ☐

Rendering Provider:

Injury / Illness Information

Chief Complaint: ☐

How long have you had this problem? ☐ How did symptoms start? ☐suddenly ☐gradually ☐chronic

Have you experienced similar problems in the past? ☐ No ☐ Yes Related to ☐ auto ☐ work

If injury related, date of injury (mm/dd/yyyy): ☐ / ☐ / ☐ ☐other ☐

REFERRING PHYSICIAN ***PRIMARY PHYSICIAN***

Referring Physician ☐ **Primary Physician** ☐

Please check and include last date of treatment for any of the following (mm/yyyy) ☐ **None**

	mm/yyyy	Back	Neck	Brain
☐ MRI	☐	☐	☐	☐
☐ CT	☐	☐	☐	☐
☐ Myelogram	☐	☐	☐	
☐ X-Rays	☐	☐	☐	
☐ Discogram	☐	☐	☐	
☐ Epidural Injection	☐	☐	☐	

	mm/yyyy	Upper Extremity	Lower Extremity
☐ EMG	☐	☐	☐

Name of facility?

☐ Physical Therapy ☐

☐ Chiropractic ☐

☐ Traction ☐

☐ Pain Clinic ☐

PAST SURGICAL HISTORY (list any **surgery** you have had with the approximate year (yyyy) ☐ **None**

☐ Back Surgery ☐☐☐☐
Surgical Procedure: ☐

☐ Back Surgery ☐☐☐☐
Surgical Procedure: ☐

☐ Neck Surgery ☐☐☐☐
Surgical Procedure: ☐

☐ Brain Surgery ☐☐☐☐
Surgical Procedure: ☐

☐ Other ☐☐☐☐
Surgical Procedure: ☐

☐ Appendectomy ☐
☐ Carpal Tunnel ☐
☐ Cataract ☐
☐ Colectomy ☐
☐ Colostomy ☐
☐ Gall Bladder ☐
☐ Gastric Bypass ☐
☐ Hernia Repair ☐
☐ Hip Replacement ☐

☐ Hysterectomy ☐
☐ Thyroidectomy ☐
☐ Mastectomy ☐
☐ Stent ☐
☐ Pacemaker ☐
☐ Heart Bypass ☐
☐ Knee Replacement ☐
☐ Knee Surgery ☐
☐ Shoulder Surgery ☐

Please continue on other side

MEDICAL HISTORY Please put a check next to the disease below if you currently have, or have have been diagnosed with in the past

- ☐ Allergies (Seasonal)
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Cancer Type of cancer:
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Hepatitis C
- ☐ HIV
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Irritable Bowel Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Renal Disease
- ☐ Seizure Disorder
- ☐ Stroke (CVA)
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Tuberculosis

Other

Other

ALLERGIES ☐ NONE

Medications you are allergic to:

Other allergies (food, seasonal, etc.)

Are you allergic to?

- ☐ Adhesive Tape
- ☐ Gadolinium/MRI Contrast?
- ☐ Latex
- ☐ CT Contrast/Kidney Dye/Iodine?

MEDICATIONS ☐ NONE

(List all medications you are currently taking including herbal and over-the-counter medications)

Medication	Dose	Frequency

SOCIAL HISTORY

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Widowed
- ☐ Partner

Do you have children? ☐ Yes ☐ No

Number of sons?

Number of daughters?

EMPLOYMENT INFORMATION

Current work status:

- ☐ Full Time
- ☐ Part Time
- ☐ Unemployed
- ☐ Disabled
- ☐ Retired
- ☐ Self Employed

Employer Name:

Job Title:

Please continue on other side

TOBACCO USE

Uses tobacco: ☐ Currently ☐ Never ☐ Formerly

Tobacco type:

☐ Cigarettes
☐ Chewing
☐ Cigar
☐ Pipe
☐ Smokeless

Amount per day: ☐ (packs, ounces, cigars, pipes, units,) per day

Number of years: ☐

Are you exposed to second hand smoke? ☐Yes ☐No

ALCOHOL/DRUG USE

Do you drink alcohol daily? ☐ Yes ☐ No ☐Formerly

Frequency ☐

Number of drinks per day: ☐

Have you ever?

☐ Sought treatment for alcohol abuse?
☐ Used illegal drugs?
☐ Had an addiction problem with narcotic pain medications?

VACCINATION

Have you received an influenza vaccination this year?

☐Yes ☐No Date: ☐

If you are 65 years or older, have you received the pneumonia vaccination?

☐Yes ☐No

FAMILY HISTORY Please indicate if your mother, father or sibling has or had any of the following diseases or it was their cause of death (COD)

☐ Patient is adopted

	Mother		Father		Sister(s)		Brother(s)	
	Now	*COD*	*Now*	*COD*	*Now*	*COD*	*Now*	*COD*
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
Aneurysm/Brain	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐
Migraine Headaches	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Psychological Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Stroke (CVA)	☐	☐	☐	☐	☐	☐	☐	☐

Other family history ☐

Please continue on other side

REVIEW OF SYSTEMS (Please check if you have had any of the following in the last 6 months) ☐ NONE

☐ Fevers	☐ Visual loss	☐ Abdominal pain
☐ Fatigue	☐ Double vision	☐ Urinary Frequency
☐ Weight loss	☐ Ringing in ears	☐ Urinary Incontinence
☐ Rash	☐ Hearing loss	☐ Urinary Retention
☐ Hives	☐ Trouble swallowing	☐ Muscle Weakness
☐ Cancer	☐ Chest pain	☐ Joint pain
☐ Bruising	☐ Heart Palpitations	☐ Joint swelling
☐ Easy bleeding	☐ Leg swelling	☐ Dizziness
☐ Swollen glands	☐ Coughing	☐ Seizures
☐ Tremors	☐ Sleep apnea	☐ Headaches
☐ Hair loss	☐ Short of breath	☐ Depression
☐ Excessive thirst	☐ Nausea	☐ Anxiety
☐ Blurry vision	☐ Vomiting	☐ Insomnia

Other:

Thank you for completing our patient information form