HealthPoint
Medical Group

Neurosurgery
MEDICAL HISTORY

Patient Name_____ M / F Age _____

Family Physician_____

Referring Physician _____

Past Medical History (Please check No or Yes for Each of the following)

No	Yes		No	Yes		No	Yes		No	Yes	
___	___	Anemia	___	___	Bleeding Tendency	___	___	Hepatitis	___	___	Emphysema
___	___	Thyroid Problem	___	___	Seizures/Epilepsy	___	___	Diabetes	___	___	Heart Problems
___	___	High Blood Pressure	___	___	Hypercholesterolemia	___	___	Asthma	___	___	Heart Attack
___	___	Depression/Anxiety	___	___	Stroke	___	___	Blood Clots			
___	___	Substance Abuse	___	___	Cancer / where? _____				Other: _____		

Past Surgical History (Please list any relevant surgery and type)

No	Yes		Date	No	Yes		Date	No	Yes		Date
___	___	Thyroid/Neck	_____	___	___	Stomach/Abdomen	_____	___	___	Back	_____
___	___	Heart	_____	___	___	Gallbladder	_____	___	___	Neck	_____
___	___	Lungs	_____	___	___	Appendix	_____	___	___	Brain	_____
___	___	Mastectomy	_____	___	___	Hysterectomy	_____	___	___	Other	_____

Present Prescription & Non-Prescription Medications: (List name, dose, frequency or supply printed list)

_____
_____
_____
_____
_____
_____

Allergies to Medications: __ No Known Allergies

_____
_____
_____

Latex sensitivity: ____ Yes ____ No

Social History: Do (did) you:

Occupation:_____

Marital Status: Single Married Divorced Widowed

Do you smoke cigarettes? No or Yes How much per day? _____ For how many years?_____

Do you drink alcohol? No or Yes How much per week?_____

Recreational Drug Use? No or Yes What and how much?_____

Family History:

	Yes	No	Medical Problem or Cause of Death
Mother	____	____	_____
Father	____	____	_____
Sister/Brother	____	____	_____
Maternal Grandparents	____	____	_____
Paternal Grandparents	____	____	_____
Children	____	____	_____

Review of Systems: Do you have these now?

No	Yes		No	Yes	
___	___	**Skin:** Psoriasis/Rash/Shingles_____	___	___	**Pulmonary:** Cough/Shortness of breath/Wheeze_____
___	___	**Head:** Headache/Migraines_____	___	___	**CV:** Chest pain/Palpitations _____
___	___	**Eyes:** Cataract/Glaucoma/Double Vision_____	___	___	**GI:** Diarrhea/constipation/incontinence_____
___	___	**Ears:** Hearing Loss/Hearing Aids _____	___	___	**GU:** Urinary incontinence _____
___	___	**Neck:** Restriction of movement _____	___	___	**MS:** Leg cramps/Swelling _____
___	___	**Nose/Mouth/Throat:** Dentures/Sinus/ Difficulty Swallowing_____	___	___	**Neuro:** Tremor/Speech Problem _____

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