

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)

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

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

<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Neck _____	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Abdomen _____	<input type="checkbox"/>	<input type="checkbox"/>	Back _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart _____	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder _____	<input type="checkbox"/>	<input type="checkbox"/>	Neck _____
<input type="checkbox"/>	<input type="checkbox"/>	Lungs _____	<input type="checkbox"/>	<input type="checkbox"/>	Appendix _____	<input type="checkbox"/>	<input type="checkbox"/>	Brain _____
<input type="checkbox"/>	<input type="checkbox"/>	Mastectomy _____	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy _____	<input type="checkbox"/>	<input type="checkbox"/>	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:

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Maternal Grandparents	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paternal Grandparents	<input type="checkbox"/>	<input type="checkbox"/>	_____
Children	<input type="checkbox"/>	<input type="checkbox"/>	_____

Review of Systems: Do you have these now?

<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Skin: Psoriasis/Rash/Shingles _____	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary: Cough/Shortness of breath/Wheeze _____
<input type="checkbox"/>	<input type="checkbox"/>	Head: Headache/Migraines _____	<input type="checkbox"/>	<input type="checkbox"/>	CV: Chest pain/Palpitations _____
<input type="checkbox"/>	<input type="checkbox"/>	Eyes: Cataract/Glaucoma/Double Vision _____	<input type="checkbox"/>	<input type="checkbox"/>	GI: Diarrhea/constipation/incontinence _____
<input type="checkbox"/>	<input type="checkbox"/>	Ears: Hearing Loss/Hearing Aids _____	<input type="checkbox"/>	<input type="checkbox"/>	GU: Urinary incontinence _____
<input type="checkbox"/>	<input type="checkbox"/>	Neck: Restriction of movement _____	<input type="checkbox"/>	<input type="checkbox"/>	MS: Leg cramps/Swelling _____
<input type="checkbox"/>	<input type="checkbox"/>	Nose/Mouth/Throat: Dentures/Sinus/ Difficulty Swallowing _____	<input type="checkbox"/>	<input type="checkbox"/>	Neuro: Tremor/Speech Problem _____