



NEUROSURGICAL ASSOCIATES, LTD.

HEALTH INFORMATION

Today's Date: _____

Patient Name: _____

Referring Physician's Name: _____

Family Physician's Name: _____

OFFICE USE ONLY:

BP _____ AGE _____

HT _____ WT _____

MEDICATION ALLERGIES: Have you had hives, skin rash, breathing problems or allergic reaction to any medications? ___ Yes ___ No

Name of Medicines You Are Allergic to:	Describe Allergic Reaction:

List All Your Current Medications:	Strength (mg)	How Many Do You Take And How Often?

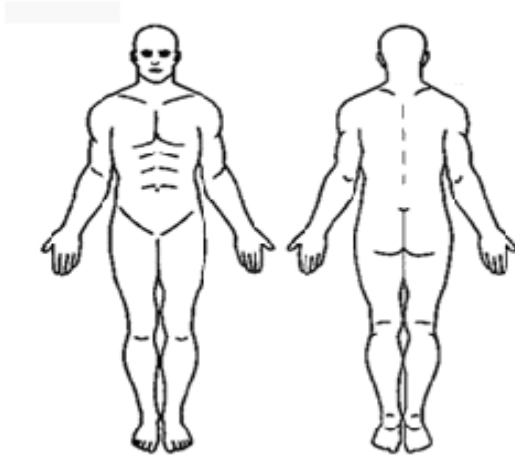
List Previous Surgeries & Dates of Surgeries:

If you have had any of the following tests done, list dates and where they were done:

Test	Date	Location
MRI		
CT Scan		
Plain Films		
CT/Myelogram		

HISTORY:

(Location) Mark with "X's" where you are having symptoms:



(Quality) Explain what type of symptoms you are experiencing, i.e., burning, tingling, stabbing, etc.

(Severity) Rate your pain on a scale of 1-10 (10 being most severe): _____

(Timing) How often do your symptoms occur? _____

(Duration) How long have you had these symptoms? _____

(Modifying Factors) What makes your symptoms better and/or worse? _____

Additional Information: _____

Mark with "X's" previous treatment(s) and date(s) for this symptom:

- | | |
|---|--|
| <input type="checkbox"/> Prescription drugs _____ | <input type="checkbox"/> Mechanical traction _____ |
| <input type="checkbox"/> Electrical stimulation _____ | <input type="checkbox"/> Steroid injections _____ |
| <input type="checkbox"/> Thermal treatments _____ | <input type="checkbox"/> Physical therapy _____ |
| <input type="checkbox"/> Chiropractic _____ | <input type="checkbox"/> Other (List) _____ |

SOCIAL HISTORY

Occupation: _____

Marital Status: Single Married Divorced Widowed

Do you have children? No Yes **How many?** _____

Do you live alone? No Yes **Who lives with you?** _____

Do you smoke? No, I have never smoked.

- No, I quit ____ years ago. At that time I was smoking ____ packs per day for ____ years.
- Yes, I've smoked ____ packs of cigarettes per day for ____ years.
- Yes, I smoke cigars or a pipe.

Do you drink alcohol? No, never or rarely.

- No, but I use to.
- Yes Daily 1 or more times a week 1 or more times a month.

Are you at risk for any infectious diseases, including blood diseases? No Yes, please explain: _____

Are your Immunizations up-to-date? No Yes

REVIEW OF SYSTEMS

Do you experience any of the following?

	Yes
Excessive Fatigue	
Fever	
Night Sweats	
Weight Loss	

	Yes
Do you have any EYE concerns/problems? (i.e. double or blurry vision, flashing lights, lazy eye, ocular abnormalities, etc.)	

	Yes
Do you wear contacts/glasses?	

	Yes
Do you have any BALANCE concerns/problems? (i.e. spinning, vertigo, dizziness, etc)	
Do you have any EAR, NOSE, THROAT concerns/problems? (i.e. hearing loss, ringing in ears, nasal drainage, pain, etc.)	

	Yes
Do you have any CARDIAC concerns/problems. (chest pain, high blood pressure, high cholesterol, etc.)	

	Yes
Do you have any RESPIRATORY concerns/problems? (i.e. asthma, shortness of breath, etc)	

	Yes
Do you have any GASTROINTESTINAL concerns/problems? (i.e. constipation, diarrhea, liver disease, swallowing difficulties, ulcers, neurogenic bowel/bladder etc.)	

Provider's Notes:

Yes

Do you have any GENITOURINARY concerns/problems? (i.e. blood in your urine, incontinence, kidney disease, etc)	
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Yes

Do you have any MUSCULOSKELATAL concerns/problems? (i.e. arm or leg pain or weakness, joint pain or swelling, etc.)	
Have you broken any bones?	

Yes

Do you have any NEUROLOGICAL concerns/problems? (i.e., coordination problems with arms and/or legs, weakness, etc.)	
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Yes

Do you have any PSYCHIATRIC concerns? (i.e., anxiety, depression, etc.)	
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Yes

Do you have diabetes?	
Do you have anemia?	
Do you have bleeding tendencies?	

Yes

Do you have food allergies?	
Inhalant (nasal) allergies?	
Immunologic Disorders?	
Are you allergic to latex ?	

Provider's Notes:

<p><i>Provider's Notes:</i></p>

The above information is accurate to the best of my knowledge.

_____ *Patient Signature* _____ *Date*

I have reviewed the above information with the patient.

_____ *Physician Signature* _____ *Date*

Date(s) Reviewed:

Patient Initials and Date:	Physician Initials and Date: