



NEUROSURGICAL ASSOCIATES, LTD.

Please complete or update your health history.

HEALTH HISTORY

Name _____ Age _____

1st Visit: Today's date _____ Reason for visit _____

2nd Visit: Today's date _____ Reason for visit _____

3rd Visit: Today's date _____ Reason for visit _____

4th Visit: Today's date _____ Reason for visit _____

5th Visit: Today's date _____ Reason for visit _____

6th Visit: Today's date _____ Reason for visit _____

In the last three months have you experienced any of the following?

	YES	NO		YES	NO
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with memory	<input type="checkbox"/>	<input type="checkbox"/>
Leg swelling	<input type="checkbox"/>	<input type="checkbox"/>	New/unusual headaches	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>	Double / poor vision	<input type="checkbox"/>	<input type="checkbox"/>
Arm or leg weakness	<input type="checkbox"/>	<input type="checkbox"/>	Numbness / tingling	<input type="checkbox"/>	<input type="checkbox"/>
Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>			

Allergies (medications, x-ray dye or contrast agents)

Allergic Reaction

_____	_____
_____	_____
_____	_____

Current Medications

Dose

of times per-day

Reason prescribed

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Major Illnesses / Admissions to hospital / Injuries / Surgeries

Diagnosis

Hospital / Physician

Year

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL REVIEW

Do you have now, or have you ever had any of the following?

	Year Diagnosed
High Blood pressure	_____
Heart Disease	_____
Stroke	_____
Diabetes	_____
Asthma	_____
Bronchitis	_____
Seizure Disorder	_____
Cancer	_____
Bleeding Problems	_____

Smoke History

years smoked _____ # packs per day _____ # years ago quit _____

Occupation

Job Title _____

How much do you lift at work? _____ How many times per day? _____

If you have filed a Worker's Compensation claim, state the date of the injury: _____

Physician Signature

Date

