NEUROSURGICAL CONSULTANTS, INC.
Patient Health History

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. Use the back of these pages for additional information. This information will be entered into the computer and you are welcome to a copy of the report.

Patient's Name _____ Date of Birth _____ Age _____
Sex: ☐ Male ☐ Female
Name of Doctor Requesting Consult_____
Name of Primary Care (Family) Physician_____
Pharmacy Preference (include location) _____

Chief Complaint

Reason for Today's Visit_____
When Did Symptoms Begin? _____

In the past, have you had? Check all that apply:
☐ MRI Scan ☐ CT Scan ☐ X-rays ☐ EMG by Dr. _____ ☐ Pain Management

Past History

Are you taking **ANY** kind of medication now? (This includes prescription, over-the-counter or herbal medications.)
If yes, please list below. If needed, use the back of this sheet for additional information. ☐ No ☐ Yes

MEDICATIONS
Please list all medications that you are currently using. (PLEASE PRINT NEATLY)

Drug	Dose	Frequency (Times Per Day)		Drug	Dose	Frequency (Times Per Day)

MEDICATION ALLERGIES
Are you allergic to ANY medication? ☐ No ☐ Yes
Are you allergic to X-Ray Contrast ☐ No ☐ Yes Type of Reaction: _____
If yes, please list below.

Name of Medication	Type of Reaction

NON-MEDICATION ALLERGIES
Do you have any non-medication allergies, such as pollens, dust, food, etc.? ☐ No ☐ Yes
If yes, please indicate what you are allergic to and type of reaction.

Patient's Name _____

Name of Allergen			**Type of Reaction**
Breathing Dust ☐ No ☐ Yes, Smoke ☐ No ☐ Yes			_____
Fumes ☐ No ☐ Yes, Animals ☐ No ☐ Yes			_____
Iodine Soaps or Shellfish	☐ No	☐ Yes	_____
Latex	☐ No	☐ Yes	_____
Tape or Adhesives	☐ No	☐ Yes	_____
Other_____	☐ No	☐ Yes	_____

PAST HEALTH:

Have you ever been diagnosed with any major health problems? Please list:

Cancer:			
Type _____	☐ No	☐ Yes	If yes, when?_____
Problems you were born with:			
Type _____	☐ No	☐ Yes	If yes, when?_____
Head & Face:			
Type _____	☐ No	☐ Yes	If yes, when?_____
Eyes, Ears, Nose, Throat and Sinus Problems:			
Type _____	☐ No	☐ Yes	If yes, when?_____
Heart and Blood Vessels:			
Heart Attack	☐ No	☐ Yes	If yes, when?_____
High Blood pressure	☐ No	☐ Yes	If yes, when?_____
Other_____	☐ No	☐ Yes	If yes, when?_____
Lungs and Respiratory:			
Asthma	☐ No	☐ Yes	If yes, when?_____
Tuberculosis	☐ No	☐ Yes	If yes, when?_____
Other_____	☐ No	☐ Yes	If yes, when?_____
Stomach and Digestive:			
Duodenal ulcer	☐ No	☐ Yes	If yes, when?_____
Hepatitis	☐ No	☐ Yes	If yes, when?_____
Stomach ulcer	☐ No	☐ Yes	If yes, when?_____
Other_____	☐ No	☐ Yes	If yes, when?_____
Male /Female Health & Urinary Tract:			
Are you pregnant? (Female)	☐ No	☐ Yes	If yes, due date? _____
Prostate enlargement (Male)	☐ No	☐ Yes	If yes, when?_____
Renal failure	☐ No	☐ Yes	If yes, when? _____
Other_____	☐ No	☐ Yes	If yes, when?_____
Bones, Joints and Muscles:			
Type _____	☐ No	☐ Yes	If yes, when?_____
Skin & Breasts:			
Type _____	☐ No	☐ Yes	If yes, when?_____
Brain and Nervous System:			
Type _____	☐ No	☐ Yes	If yes, when?_____
Mental & Emotional:			
Type _____	☐ No	☐ Yes	If yes, when?_____
Glands, Hormones, and Sugar Control:			
Diabetes	☐ No	☐ Yes	If yes, when?_____
Thyroid deficiency	☐ No	☐ Yes	If yes, when?_____
Thyroid excess	☐ No	☐ Yes	If yes, when?_____

Patient's Name _____

Blood & Lymph Node problems:
Type _____ ☐ No ☐ Yes If yes, when?_____

Allergies, Immune & Infectious Problems:
Type _____ ☐ No ☐ Yes If yes, when?_____

Have you ever been diagnosed with any other major health problem not listed above?
☐ No ☐ Yes

If yes, please list diagnosis and year the diagnosis was made.

_____
_____
_____

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ No ☐ Yes
If yes, please list what sort of problems.

_____

Have you ever had surgery? ☐ No ☐ Yes
If yes, list any surgeries and when they were done.

_____

Have you been hospitalized for a medical problem before? ☐ No ☐ Yes
If yes, list hospitalizations, the reason for admission and the date.

_____

IMMUNIZATION SCREENING

Pneumonia Vaccination Screening - Everyone Over Age 65 Must Answer the Following:
Date of Pneumonia Vaccination: _____ Date of Pneumonia Re-Vaccination: _____

Flu Vaccination (should be September 1- February 28) - Everyone Over Age 50 Must Answer the Following:
Date of Last Influenza (flu) Vaccination: _____
If not taken, indicate the reason: _____

CANCER SCREENING (Enter Date or "Never"):

Everyone Must Answer the Following (Enter Date or "Never" or that you had a colectomy or colon removal):
Colonoscopy: _____ Fecal Occult Blood Testing: _____
Sigmoidoscopy: _____

Women Only Must Answer the Following (Enter Date or "Never" or that you had a hysterectomy):
Mammogram: _____ Pap Smear: _____

SERIOUS INJURIES

Have you ever had a serious injury, such as head, neck, back, or other injury? ☐ No ☐ Yes
If yes, list and describe the type of injury and when it occurred.

_____
_____
_____

Patient's Name _____

FAMILY HISTORY

If Deceased Check	☐ Mother		☐ Father	
Cause of Death	_____		_____	
Specific Anesthesia Problem	☐ Mother	☐ Father	☐ Brother	☐ Sister
Heart and Blood Vessels:				
Heart Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
High Blood Pressure	☐ Mother	☐ Father	☐ Brother	☐ Sister
Lungs and Respiratory:				
Asthma	☐ Mother	☐ Father	☐ Brother	☐ Sister
Cancer				
Breast	☐ Mother	☐ Father	☐ Brother	☐ Sister
Lung	☐ Mother	☐ Father	☐ Brother	☐ Sister
Ovarian	☐ Mother			☐ Sister
Prostate		☐ Father	☐ Brother	
Brain and Nervous System:				
Dementia	☐ Mother	☐ Father	☐ Brother	☐ Sister
Stroke	☐ Mother	☐ Father	☐ Brother	☐ Sister
Aneurysm	☐ Mother	☐ Father	☐ Brother	☐ Sister
Brain Tumor	☐ Mother	☐ Father	☐ Brother	☐ Sister
Spine Problems	☐ Mother	☐ Father	☐ Brother	☐ Sister
Diabetes	☐ Mother	☐ Father	☐ Brother	☐ Sister
Thyroid Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
Blood & Lymph Node problems:				
Anemia	☐ Mother	☐ Father	☐ Brother	☐ Sister
Bleeding/clotting problem	☐ Mother	☐ Father	☐ Brother	☐ Sister
Other_____	☐ Mother	☐ Father	☐ Brother	☐ Sister

SOCIAL HISTORY

☐ Check here if you are retired.
What is or was your occupation? _____
What is the highest level of education you have had? _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Do you have Children? ☐ No ☐ Yes How many? _____

Do you smoke? ☐ Yes, I've smoked _____ packs of cigarettes per day for _____years.
☐ Yes, I smoke cigars. ☐ Yes, I smoke a pipe.
☐ No, I have never smoked.
☐ No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____ years.

Patient's Name _____

Do you drink alcohol? ☐ Yes What kind and how much? _____
☐ No, never ☐ No, but I used to. At that time I was drinking _____ per day for _____ years.

Have you ever had a substance abuse problem? ☐ Yes ☐ No
If Yes, what Substance(s) and when? _____

Do you have Advanced Directives (Living Will) ☐ Yes ☐ No If Yes, please submit a copy to us.

Are you: ☐ Left Handed or ☐ Right Handed

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

REVIEW OF SYSTEMS: Please describe any **symptoms** you are currently having and are not covered elsewhere. You do not need to list specific diagnoses you have listed under PAST HEALTH. Check the "NONE" box for no symptoms.

NONE

General Health: _____ ☐

Eyes: _____ ☐

Ears, Nose, Mouth, and Throat: _____ ☐

Heart and Blood Vessels: _____ ☐

Lungs & Breathing: _____ ☐

Stomach and Digestive System: _____ ☐

Kidneys, Bladder and Reproductive Organs: _____ ☐

Bones, Joints and Muscles: _____ ☐

Skin and Breasts: _____ ☐

Brain and Nervous System: _____ ☐

Mental and Emotional Health: _____ ☐

Infections and Immune System: _____ ☐

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

_____
Patient Signature & Date

5/19/2011 2:15 PM