NeuroSpine
GET YOUR LIFE BACK™

PATIENT HEALTH HISTORY FORM
NEUROSURGERY

PATIENT INFORMATION

Primary Reason For Your Visit? _____

Name:_____ DOB: _____ Occupation: _____

Ethnicity: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic

Referring Doctor: _____ Primary Doctor: _____

Primary Insurance: _____ Pharmacy: _____

MEDICATIONS/ALLERGIES *PLEASE BRING A LIST OF CURRENT MEDICATIONS TO APPOINTMENT*

Are you on any blood thinning medications?: ☐Aspirin ☐Plavix ☐Coumadin ☐Xarelto ☐Eliquis ☐Pradaxa ☐Effient

☐Other: _____ Allergies: _____

MOST RECENT IMAGING

When: _____ Where: _____ What: _____

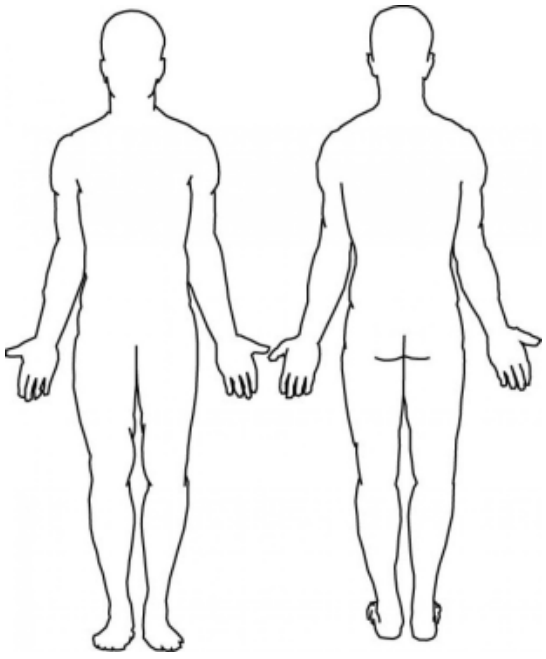
When: _____ Where: _____ What: _____

SYMPTOMS Describe your symptoms. Please fill out and use the diagram below to assist you in your description.

Mark on the drawings according to where you hurt. Please indicate on the drawing where you feel any of the following symptoms by placing the marks shown here on the DIAGRAM KEY.

DIAGRAM KEY

*Numbness=**N** Ache=**A** Weakness=**W***
*Burning=**B** Stabbing=S Pins & Needles=**P***



How Long Have You Had These Symptoms? _____

Average pain score (0=no pain to 10=worst)? _____

Do you have any weakness? ☐Yes ☐No

Where: _____

Do you have numbness/tingling? ☐Yes ☐No

Where: _____

What Makes Your Pain Better?

☐Laying ☐Sitting ☐Standing ☐Walking ☐Rest ☐Heat

☐Ice ☐Position Change ☐NSAIDs (Ibuprofen, Celebrex, etc.)

☐Narcotics (name): _____

What Makes Your Pain Worse?

☐Laying ☐Sitting ☐Standing ☐Walking ☐Twisting ☐Lifting

☐Pushing/Pulling ☐Sit to stand ☐Getting out of bed ☐Carrying

Previously Tried Treatment(s):

Physical Therapy ☐No ☐ Yes (when?) _____ Was it helpful? _____

Steroid Injections ☐No ☐ Yes (when?) _____ Was it helpful? _____

Other Therapies:

☐Chiropractic/Massage ☐Exercise ☐Aquatic ☐Acupuncture

Is this the result of a specific injury or accident? ☐ Yes ☐ No Date of accident: _____

Are you involved in litigation regarding this condition? ☐ Yes ☐ No Type of accident: _____

MEDICAL HISTORY (Check **ALL** That Apply)

- ☐Atrial Fibrillation
- ☐Anemia
- ☐Brain Aneurysm
- ☐Anxiety Disorder
- ☐Arthritis
- ☐Asthma
- ☐Back Problems
- ☐Bleeding Disorder
- ☐CAD
- ☐COPD
- ☐Cancer
- ☐Depression
- ☐Diabetes
- ☐GERD
- ☐HIV or AIDS
- ☐Head Trauma/Injury
- ☐Headaches/Migraines
- ☐Heart Attack (MI)
- ☐Aortic Aneurysm
- ☐Hepatitis B/C
- ☐Thyroid Problems
- ☐Hernia
- ☐High Cholesterol
- ☐Hypertension
- ☐Kidney Disease
- ☐ Liver Disease
- ☐Lung Disease
- ☐Multiple Sclerosis
- ☐Muscle/Joint/Bone Pain
- ☐Neck Injury
- ☐Neuropathy
- ☐Obesity
- ☐Osteoporosis
- ☐Pacemaker
- ☐Peripheral Vascular Disease
- ☐Pulmonary Embolism
- ☐Seizure/Epilepsy
- ☐Sleep Apnea
- ☐Stroke
- ☐Other _____

SURGICAL HISTORY

Surgery: _____ Surgery: _____
Surgery: _____ Surgery: _____
Surgery: _____ Surgery: _____

FAMILY HEALTH HISTORY *Place the letter of your family member relationship that has a condition listed below.*

M-Mother; **F**-Father; **B**-Brother; **S**-Sister; **MGM**-Maternal Grandmother; **MGF**-Maternal Grandfather; **PGM**-Paternal Grandmother; **PGF**-Paternal Grandfather

Addiction_____ Heart Attack _____ Cancer_____ Osteoporosis_____

Hypertension_____ Rheumatoid Arthritis_____ Multiple Sclerosis _____ Diabetes_____

Back Problems_____ Bleeding Disorder_____ Alzheimer's_____ Stroke_____

YOUR CURRENT SYMPTOMS (Check **ALL** That Apply)

- ☐Numbness/tingling
- ☐Muscle weakness
- ☐Difficulty walking
- ☐Seizures
- ☐Headaches
- ☐Change of vision
- ☐Depression
- ☐Nervousness
- ☐Chest pain
- ☐Irregular heart beat
- ☐Environmental allergies
- ☐Heat or cold intolerance
- ☐Chronic cough
- ☐Shortness of breath
- ☐Coughing up blood
- ☐Voice changes
- ☐Chronic sinus problems
- ☐Abdominal pain
- ☐Vomiting blood
- ☐Frequent diarrhea
- ☐Severe heart burn
- ☐Constipation
- ☐Excessive urination
- ☐Burning with urination
- ☐Lack of bladder control
- ☐Change in sexual function
- ☐Recurrent fever, chills, sweats
- ☐Recent weight loss
- ☐Enlarged lymph nodes
- ☐Extreme fatigue
- ☐Excessive thirst
- ☐Easy bruising
- ☐Frequent bleeding
- ☐Abnormal mole
- ☐Skin rash
- ☐Other: _____

SOCIAL HISTORY

Tobacco Use: ☐Yes ☐No _____ # packs per day | What age/year did you start smoking? _____

Former Smoker? ☐Yes ☐No | How long ago did you quit? _____

Recreational Drug Use: ☐Yes ☐No | How often and what substance? _____

Alcohol Use: ☐Yes ☐No ___ # drinks per ☐Day ☐Week ☐Month

Exercise: ☐Occasional ☐Moderate ☐Frequent ☐ Stopped Due to Pain ☐ None

Relationship Status: ☐Married ☐Single ☐Widow | Hand Dominance: ☐Right ☐Left ☐Ambidextrous

Do You Drink Caffeine: ☐Yes ☐No

LIVING SITUATION

Do you live alone?: ☐Yes ☐No

If you need surgery, do you have someone who can assist you in your recovery? ☐Yes ☐No

I attest that all information provided is true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____