Neurosurgery Medical History

MEDICAL HISTORY

Patient Name______________________________ M / F Age __________

Family Physician______________________________

Referring Physician ______________________________

Past Medical History (Please check No or Yes for Each of the following)

No	Yes		No	Yes		No	Yes		No	Yes	
___	___	Anemia	___	___	Bleeding Tendency	___	___	Hepatitis	___	___	Emphysema
___	___	Thyroid Problem	___	___	Seizures/Epilepsy	___	___	Diabetes	___	___	Heart Problems
___	___	High Blood Pressure	___	___	Hypercholesterolemia	___	___	Asthma	___	___	Heart Attack
___	___	Depression/Anxiety	___	___	Stroke	___	___	Blood Clots			
___	___	Substance Abuse	___	___	Cancer / where? ___________						Other: __________

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

No	Yes	Date	No	Yes	Date	No	Yes	Date
___	___	Thyroid/Neck__________	___	___	Stomach/Abdomen__________	___	___	Back__________
___	___	Heart __________	___	___	Gallbladder__________	___	___	Neck __________
___	___	Lungs __________	___	___	Appendix__________	___	___	Brain__________
___	___	Mastectomy __________	___	___	Hysterectomy__________	___	___	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:

	Yes	No	Medical Problem or Cause of Death
Mother	____	____	______________________________
Father	____	____	______________________________
Sister/Brother	____	____	______________________________
Maternal Grandparents	____	____	______________________________
Paternal Grandparents	____	____	______________________________
Children	____	____	______________________________

Review of Systems: Do you have these now?

No	Yes		No	Yes	
___	___	**Skin:** Psoriasis/Rash/Shingles__________	___	___	**Pulmonary:** Cough/Shortness of breath/Wheeze_______
___	___	**Head:** Headache/Migraines__________	___	___	**CV:** Chest pain/Palpitations __________
___	___	**Eyes:** Cataract/Glaucoma/Double Vision_____	___	___	**GI:** Diarrhea/constipation/incontinence__________
___	___	**Ears:** Hearing Loss/Hearing Aids __________	___	___	**GU:** Urinary incontinence __________
___	___	**Neck:** Restriction of movement __________	___	___	**MS:** Leg cramps/Swelling __________
___	___	**Nose/Mouth/Throat:** Dentures/Sinus/ Difficulty Swallowing__________	___	___	**Neuro:** Tremor/Speech Problem __________

BayCare Medical Group