Neurosurgery New Patient History

Name: _____ Last 4 digits of SS# _____ Age: _____

Reason for visit: _____

Was this an accident? ☐ Yes ☐ No If Yes, list exact Date (day, month, year) _____

☐ Motor vehicle accident ☐ Workers Comp Injury

Previous Trauma or Injury to head, neck, back or spine? _____

Referred by: _____ Primary Care Physician: _____

Other Physicians seen for this problem: _____

Treatment for current problem: ☐ X-rays ☐ MRI scans ☐ Physical Therapy ☐ Medication

Current Medications and Dosages: _____

Medication Allergies: ☐ Yes ☐ No If yes, please list: _____

Are you allergic to: ☐ No ☐ X-ray IV Contrast Dye ☐ Iodine ☐ Seafood/Shellfish

Previous Surgeries: _____

History of Present/Past Illnesses: please check all that apply ☐ No illness

☐ Aids/HIV	☐ Fibromyalgia	☐ Lung/asthma	☐ Osteoarthritis
☐ Anxiety	☐ Glaucoma	☐ Lupus	☐ Rheumatoid Arthritis
☐ Cancer	☐ Heart/CAD	☐ Reflux	☐ Are you currently pregnant?
☐ Cataracts	☐ Hepatitis	☐ Seizures	☐ Other
☐ Circulatory/Vascular	☐ High Blood Pressure	☐ Thyroid	_____
☐ Depression	☐ High Cholesterol	☐ TB	_____
☐ Diabetes	☐ Kidney	☐ Ulcers	_____

Social and Family History:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Occupation: _____ ☐ Retired ☐ Disabled

Habits: Do you Smoke? ☐ Yes ☐ No Packs per day _____ When did you quit? _____

Do you drink Alcohol? ☐ Yes ☐ No How much? _____ How often? _____

Children: ☐ Yes ☐ No How many? _____ Living _____ Deceased _____

Mother: Living/well _____ Deceased/Cause _____

Father: Living/well _____ Deceased/Cause _____

Siblings: Living well _____ Deceased/Cause _____

List any Diseases present in your family: _____

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost::

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)