

# Neurosurgical Associates, L.L.P.

## Patient Health History Form

Patient name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Name of physician requesting this consultation: \_\_\_\_\_

### Chief Complaint

Reason for today's visit? \_\_\_\_\_

### Past History

Please list any prior major illnesses and/or injuries:

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Surgeries/Hospitalizations	Year	Complications

Have you ever had problems with anesthesia?  Yes  No

Current Medications(s) including Aspirin	Dose	Frequency

**ALLERGIES/REACTIONS TO MEDICATIONS, ANESTHETICS OR MATERIALS:**

### Family History

Do you have a family history of trouble with anesthesia?  Yes  No

Do you have a family history of easy bleeding?  Yes  No

### Social History

Do you smoke?

Yes, I've smoked \_\_\_\_\_ packs of cigarettes per day for \_\_\_\_\_ years.

Yes, I smoke cigars or a pipe.

No, I have never smoked.

No, I quit \_\_\_\_\_ years ago. At that time I was smoking \_\_\_\_\_ packs per day for \_\_\_\_\_ years.

Do you drink alcohol?

No, never (or rarely)  No, but I used to

Yes  Daily  1 or more times a week  1 or more times a month

**Review of Systems**

**Are you currently, or have you had, problems with:**

*Circle One*

*Constitutional*  
 Weight gains            Yes    No  
 Weight loss            Yes    No  
 Night sweats            Yes    No  
 Insomnia                Yes    No

*Eyes*  
 Double vision            Yes    No  
 Visual loss                Yes    No

*Ear, Nose, Throat and Mouth*  
 Hearing loss              Yes    No  
 Noise/ringing in ears    Yes    No  
 Nasal congestion        Yes    No  
 Nasal drainage          Yes    No  
 Sore throat                Yes    No  
 Trouble swallowing      Yes    No  
 Hoarseness                Yes    No

*Cardiovascular*  
 Chest pain or angina    Yes    No  
 Heart trouble            Yes    No  
 Rheumatic fever         Yes    No  
 Heart murmur            Yes    No  
 High blood pressure     Yes    No

*Neurological*  
 Numbness                Yes    No  
 Weakness                Yes    No  
 Stroke                    Yes    No  
 Headache                Yes    No

*Psychiatric*  
 Depression                Yes    No

*Allergic/Immunologic*  
 Sneezing                 Yes    No  
 Itchy eyes/nose          Yes    No  
 Itchy throat                Yes    No  
 Skin rash                 Yes    No  
 HIV                         Yes    No

*Circle One*

*Respiratory*  
 Asthma                    Yes    No  
 Cough up blood          Yes    No  
 TB                         Yes    No  
 Pneumonia                Yes    No  
 Trouble breathing        Yes    No  
 Snoring                    Yes    No

*Gastrointestinal*  
 Indigestion or  
 Heartburn                Yes    No  
 Ulcer                      Yes    No  
 Hepatitis                 Yes    No  
 Jaundice                 Yes    No  
 Blood in stool            Yes    No  
 Black, tarry stools        Yes    No

*Genitourinary*  
 Bladder trouble          Yes    No  
 Prostate disease         Yes    No  
 Kidney disease            Yes    No

*Musculoskeletal*  
 Arthritis                 Yes    No

*Endocrine*  
 Diabetes                 Yes    No  
 Thyroid disease          Yes    No

*Hematologic*  
 Bleeding disorder        Yes    No  
 Easy bleeding             Yes    No

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

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

I have reviewed the above information with the patient.

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date*