

LABEL

PERSONAL INFORMATION

Name: _____ Home Phone: _____

(Please circle appropriate: Mr. Mrs. Miss Ms. Dr.) Work Phone: _____

Address _____

Name of Primary Doctor: _____ Other Treating Providers: _____

Age: ____ Marital Status: ____ Right/Left Handed: ____ Are you currently employed: ____ Yes ____ No

Job description/Occupation: _____ Place of Employment: _____

Do you use/smoke tobacco products? ____ Yes ____ No How many packs a day? _____

Do you drink alcoholic beverages? ____ Yes ____ No Number of drinks per week _____

Do you use illegal drugs of any kind? ____ Yes ____ No _____ Beer ____ Wine ____ Other

Please briefly state the reason for your visit today to see a neurosurgeon:

PAST MEDICAL HISTORY

Please check the conditions for which you are currently or have been under the care by a physician:

	NOW	PAST		NOW	PAST
High blood pressure			Stomach/intestinal ulcers		
Angina/chest pain			Heartburn/GERD		
Heart attack/heart failure			Thyroid problems		
Blockage of heart arteries			Diabetes		
Kidney stones			Hepatitis/liver problems		
Sinus problems			Cancer		
Seasonal allergies			Bleeding problems		
Asthma/Bronchitis			TIA/Stroke		
Emphysema/COPD			Seizures		
Pneumonia			Sleep apnea		
Neck/back injury			Migraine headaches		
Arthritis of joints			Rheumatoid arthritis		

Have you been hospitalized other than for outpatient surgery or testing in the last year? _____

PAST SURGERIES/PROCEDURES Please check all of the following that apply:

- Tonsils/Adenoid Sinus Thyroid Ear tubes Nose
 Cataract/Glaucoma Appendix Gallbladder Hysterectomy Tubal Ligation
 Colon Stomach Ulcer Breast Tooth extraction
 Skin cancer removal Carotid Heart bypass Peripheral bypass

Previous brain or spine surgery:

Date: _____ Surgeon: _____ Hospital: _____

Date: _____ Surgeon: _____ Hospital: _____

↓ Please complete the back of this two-sided form.