

CONNECTICUT NEUROSURGERY P.C.

Patient Health History

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. Use the back of these pages for additional information.

Patient's Name _____ Date of Birth _____ Age _____
 Sex: Male Female
 Name of Doctor Requesting Consult _____
 Name of Primary Care (Family) Physician _____
 Pharmacy Preference (include location) _____

Chief Complaint

Reason for Today's Visit _____
 When Did Symptoms Begin? _____
 What Other Treatments Have You Tried? Check all that apply:
 Non-steroid Anti-inflammatory Medications Physical Therapy Chiropractic
 Acupuncture Surgery Epidural Steroids Pain Management
 Other: _____

What Tests Have You Had? Check all that apply:
 MRI Scan CT Scan X-rays EMG by Dr. _____

Current problem is a result of a(n): Check all that apply:
 Car Accident Work Accident Other Accident Other
 How Did Accident Occur or Symptoms Begin? _____

Past History

Are you taking **ANY** kind of medication now? (This includes prescription, over-the-counter or herbal medications.)
 If yes, please list below. If needed, use the back of this sheet for additional information. No Yes

(TAB 1) MEDICATIONS

Please list all medications that you are currently using. (PLEASE PRINT NEATLY)

Drug	Dose	Frequency (Times Per Day)		Drug	Dose	Frequency (Times Per Day)

Patient's Name _____

(TAB 2) MEDICATION ALLERGIES

Are you allergic to ANY medication? No Yes
Are you allergic to X-Ray Contrast No Yes Type of Reaction: _____

If yes, please list below.

Name of Medication	Type of Reaction

(TAB 3) NON-MEDICATION ALLERGIES

Do you have any non-medication allergies, such as pollens, dust, food, etc.? No Yes
If yes, please indicate what you are allergic to and type of reaction.

Name of Allergen

Type of Reaction

Breathing Dust, Smoke, Fumes or Animals	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Iodine Soaps or Shellfish	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Latex	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Tape or Adhesives	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Other _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

(TAB 4) PAST HEALTH:

Have you ever been diagnosed with any major health problems? Please list:

Cancer:

Type _____ No Yes If yes, when? _____

Problems you were born with:

Type _____ No Yes If yes, when? _____

Head & Face:

Type _____ No Yes If yes, when? _____

Eyes, Ears, Nose, Throat and Sinus Problems:

Type _____ No Yes If yes, when? _____

Heart and Blood Vessels:

Heart Attack No Yes If yes, when? _____

High Blood pressure No Yes If yes, when? _____

Other _____ No Yes If yes, when? _____

Lungs and Respiratory:

Asthma No Yes If yes, when? _____

Tuberculosis No Yes If yes, when? _____

Other _____ No Yes If yes, when? _____

Stomach and Digestive:

Duodenal ulcer No Yes If yes, when? _____

Hepatitis No Yes If yes, when? _____

Stomach ulcer No Yes If yes, when? _____

Other _____ No Yes If yes, when? _____

Patient's Name _____

Male /Female Health & Urinary Tract:

- Are you pregnant? (Female) No Yes If yes, due date? _____
Prostate enlargement (Male) No Yes If yes, when? _____
Renal failure No Yes If yes, when? _____
Other _____ No Yes If yes, when? _____

Bones, Joints and Muscles:

Type _____ No Yes If yes, when? _____

Skin & Breasts:

Type _____ No Yes If yes, when? _____

Brain and Nervous System:

Type _____ No Yes If yes, when? _____

Mental & Emotional:

Type _____ No Yes If yes, when? _____

Glands, Hormones, and Sugar Control:

- Diabetes No Yes If yes, when? _____
Thyroid deficiency No Yes If yes, when? _____
Thyroid excess No Yes If yes, when? _____

Blood & Lymph Node problems:

Type _____ No Yes If yes, when? _____

Allergies, Immune & Infectious Problems:

- Hepatitis No Yes If yes, when? _____
Rheumatoid Arthritis No Yes If yes, when? _____
Other serious Infection _____ No Yes If yes, when? _____

Have you ever been diagnosed with any other major health problem not listed above?

No Yes

If yes, please list diagnosis and year the diagnosis was made.

(TAB 5) SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? No Yes

If yes, please list what sort of problems.

Have you ever had surgery? No Yes

If yes, list any surgeries and when they were done.

Have you been hospitalized for a medical problem before? No Yes

If yes, list hospitalizations, the reason for admission and the date.

(TAB 6) SERIOUS INJURIES

Have you ever had a serious injury, such as head, neck, back, or other injury? No Yes

If yes, list and describe the type of injury and when it occurred.

Patient's Name _____

(TAB 7/8) FAMILY HISTORY

If Deceased Check Cause of Death

Mother

Father

Specific Anesthesia Problem

Mother

Father

Brother

Sister

Heart and Blood Vessels:

Heart Disease

Mother

Father

Brother

Sister

High Blood Pressure

Mother

Father

Brother

Sister

Lungs and Respiratory:

Asthma

Mother

Father

Brother

Sister

Lung Cancer

Mother

Father

Brother

Sister

Breast Cancer

Mother

Father

Brother

Sister

Brain and Nervous System:

Dementia

Mother

Father

Brother

Sister

Stroke

Mother

Father

Brother

Sister

Aneurysm

Mother

Father

Brother

Sister

Brain Tumor

Mother

Father

Brother

Sister

Spine Problems

Mother

Father

Brother

Sister

Diabetes

Mother

Father

Brother

Sister

Thyroid Disease

Mother

Father

Brother

Sister

Blood & Lymph Node problems:

Anemia

Mother

Father

Brother

Sister

Bleeding/clotting problem

Mother

Father

Brother

Sister

Other _____

Mother

Father

Brother

Sister

(TAB 9) SOCIAL HISTORY

Check here if you are retired.

What is or was your occupation? _____

What is the highest level of education you have had? _____

Marital Status: Single Married Divorced Widowed

Do you have Children? No Yes How many? _____

Do you smoke? Yes, I've smoked _____ packs of cigarettes per day for _____ years.

Yes, I smoke cigars or 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? Yes What kind and how much? _____

No, never No, but I used to. At that time I was drinking _____ per day for _____ years.

Patient's Name _____

Have you ever had a substance abuse problem? Yes No

If Yes, what Substance(s) and when? _____

Height: _____ Weight _____

Are you: Left Handed or Right Handed

Do you live alone? No Yes Who lives with you? _____

(TAB 10) REVIEW OF SYSTEMS: Please describe any problems you are currently having in the following areas or check box for "NONE":

	NONE
<i>General Health:</i> _____	<input type="checkbox"/>
<i>Eyes:</i> _____	<input type="checkbox"/>
<i>Ears, Nose, Mouth, and Throat:</i> _____	<input type="checkbox"/>
<i>Heart and Blood Vessels:</i> _____	<input type="checkbox"/>
<i>Lungs & Breathing:</i> _____	<input type="checkbox"/>
<i>Stomach and Digestive System:</i> _____	<input type="checkbox"/>
<i>Kidneys, Bladder and Reproductive Organs:</i> _____	<input type="checkbox"/>
<i>Bones, Joints and Muscles:</i> _____	<input type="checkbox"/>
<i>Skin and Breasts:</i> _____	<input type="checkbox"/>
<i>Brain and Nervous System:</i> _____	<input type="checkbox"/>
<i>Mental and Emotional Health:</i> _____	<input type="checkbox"/>
<i>Infections and Immune System:</i> _____	<input type="checkbox"/>

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

Patient Signature & Date

Physician Signature & Date