MAIN LINE HEALTH JEFFERSON NEUROSURGERY

DATE: ____________________

DOB: ____________________

NAME: ____

REASON FOR TODAY'S VISIT: ____

____

When did your symptoms start? ____

MEDICAL HISTORY:

____
____
____
____
____
____

OPERATIONS/SURGERIES — PLEASE GIVE YEAR:

____
____
____
____
____
____

PHARMACY: ____________________ **CITY & STATE:** ____________________ **PHONE #:** ____________________

MEDICATION LIST (provide dosage):

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________
9. ____________________
10. ____________________

ALLERGIES TO DRUG, FOOD, ETC:	REACTION:	SEVERITY:

SOCIAL HISTORY:

Cigarettes: ☐ Yes ☐ No: (packs per day) ____________________ **Former Smoker:** (Quit Year) ____________________

Smokeless Tobacco: ☐ Yes ☐ No

Alcohol: ☐ Yes ☐ No **Type:** ☐ Beer ☐ Wine ☐ Liquor **How Often:** ☐ Daily ☐ Socially ☐ Occasionally

FAMILY HISTORY:

Mother: ☐ Alive ☐ Deceased Age: __________ Illness or cause of death: ____________________

Father: ☐ Alive ☐ Deceased Age: __________ Illness or cause of death: ____________________

Brother: ☐ Alive ☐ Deceased Age: __________ Illness or cause of death: ____________________

Sister: ☐ Alive ☐ Deceased Age: __________ Illness or cause of death: ____________________

NAME:______________________________ DOB:______________

NEURO MEDICAL HISTORY:

Alzheimer's Disease	Y ☐ / N ☐	Disc Problem — Cervical	Y ☐ / N ☐	Headache	Y ☐ / N ☐
Aneurysm	Y ☐ / N ☐	Disc Problem — Lumbar	Y ☐ / N ☐	Lower Back Pain	Y ☐ / N ☐
Carotid Disease	Y ☐ / N ☐	Disc Problem — Thoracic	Y ☐ / N ☐	Memory Loss	Y ☐ / N ☐
Cerebral Palsy	Y ☐ / N ☐	Neck Pain	Y ☐ / N ☐	Neuropathy	Y ☐ / N ☐
Concussion	Y ☐ / N ☐	Neurofibromatosis	Y ☐ / N ☐	Seizure	Y ☐ / N ☐
Difficulty Walking	Y ☐ / N ☐	Head Injury	Y ☐ / N ☐	Spinal Headache	Y ☐ / N ☐

REVIEWS OF SYSTEMS-PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH:

CONSTITUTION:

- Chills Y ☐ / N ☐
- Fatigue Y ☐ / N ☐
- Fever Y ☐ / N ☐
- Weight Change Y ☐ / N ☐

GI:

- Abdominal Swelling Y ☐ / N ☐
- Abdominal Pain Y ☐ / N ☐
- Blood in Stool Y ☐ / N ☐
- Constipation Y ☐ / N ☐
- Diarrhea Y ☐ / N ☐
- Nausea Y ☐ / N ☐

MUSCULOSKELETAL:

- Joint Pain Y ☐ / N ☐
- Back Pain Y ☐ / N ☐
- Gait Problem Y ☐ / N ☐
- Muscle Y ☐ / N ☐
- Neck Pain Y ☐ / N ☐
- Neck Stiffness Y ☐ / N ☐

ENT:

- Facial Swelling Y ☐ / N ☐
- Hearing Loss Y ☐ / N ☐
- Nosebleeds Y ☐ / N ☐
- Voice Change Y ☐ / N ☐
- Excessive Thirst Y ☐ / N ☐
- Sensitivity To Light Y ☐ / N ☐
- Visual Disturbances Y ☐ / N ☐

ENDOCRINE:

- Cold Intolerance Y ☐ / N ☐
- Heat Intolerance Y ☐ / N ☐
- Excessive Thirst Y ☐ / N ☐
- Excessive Appetite Y ☐ / N ☐

NEUROLOGICAL:

- Headaches Y ☐ / N ☐
- Numbness Y ☐ / N ☐
- Weakness Y ☐ / N ☐
- Seizures Y ☐ / N ☐
- Speech Difficulty Y ☐ / N ☐
- Dizziness Y ☐ / N ☐

RESPIRATORY:

- Sleep Apnea Y ☐ / N ☐
- Chest Tightness Y ☐ / N ☐
- Cough Y ☐ / N ☐
- Shortness of Breath Y ☐ / N ☐
- Wheezing Y ☐ / N ☐

GENITOURINARY:

- Urine Decreased Y ☐ / N ☐
- Difficulty Urinating Y ☐ / N ☐
- Painful Urinating Y ☐ / N ☐
- Bloody Urine Y ☐ / N ☐

HEMATOLOGIC:

- Bruise Easily Y ☐ / N ☐

CARDIOVASCULAR:

- Chest Pain Y ☐ / N ☐
- Leg Swelling Y ☐ / N ☐
- Heart Palpitations Y ☐ / N ☐

ALLERGIC/IMMUNOLOGICAL:

- Environmental Allergies Y ☐ / N ☐
- Food Allergies Y ☐ / N ☐

PSYCHIATRIC:

- Nervous Y ☐ / N ☐
- Anxious Y ☐ / N ☐
- Sad or Depressed Y ☐ / N ☐
- Sleep Disturbance Y ☐ / N ☐