Dallas Neurosurgical and Spine Associates, P.A
Patient Health History

Name: _____ DOB: _____ Date: _____

Reason for your visit (Chief complaint): _____

Past Medical History

Please check corresponding box if you have ever had any of the following medical conditions:

Heart Problems	
Congestive Heart Failure	☐
Deep Vein Thrombosis	☐
Heart Attack	☐
Heart Murmur	☐
High Blood Pressure	☐
High Cholesterol	☐
Irregular Heartbeat (Atrial Fibrillation)	☐
Other: _____	☐

Lung Problems	
Asthma	☐
Chronic Obstructive Pulmonary Disease	☐
Emphysema	☐
Pneumonia	☐
Pulmonary Embolism	☐
Other: _____	☐

Gastrointestinal Problems	
Cirrhosis	☐
Gastric ulcer	☐
Gastroesophageal Reflux Disease	☐
Hepatitis	☐
Rectal bleeding	☐
Other: _____	☐

Endocrine Problems	
Diabetes, Type I (Juvenile Onset)	☐
Diabetes, Type II (Adult Onset)	☐
Thyroid disorder – Type: _____	☐
Other: _____	☐

Musculoskeletal	
Fibromyalgia	☐
Osteoarthritis	☐
Osteoporosis	☐
Rheumatoid Arthritis	☐
Other: _____	☐

Neurological	
Alzheimer's Disease	☐
Cerebral Aneurysm	☐
Closed Head Injury	☐
Essential Tremor	☐
Hydrocephalus	☐
Migraines	☐
Multiple Sclerosis	☐
Parkinson's Disease	☐
Peripheral Neuropathy	☐
Seizure Disorder	☐
Stroke	☐
TIA	☐
Other: _____	☐

Urinary Problems	
Kidney Infection (pyelonephritis)	☐
Kidney Stones	☐
Prostate enlargement	☐
Urinary Tract Infection	☐
Other: _____	☐

Blood Disorders	
Anemia	☐
Bleeding Disorder	☐
Blood transfusion	☐
HIV +	☐
Other: _____	☐

Cancer	
Type: _____	☐
Type: _____	☐

Anesthesia	
Have you ever had a reaction to anesthesia?	☐
Please Describe: _____	☐

Other: _____	

Name: _____

Past Surgical History

Please list all previous surgeries:

	Date	Procedure	Surgeon
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Preferred Pharmacy

Please provide contact information for your preferred pharmacy:

Pharmacy Name	Address	City	State	Zip	Phone

Medications

Medication (please include prescription, over the counter and herbal)	Dose (mg)	Times Taken Per Day

Drug Allergies and Reactions

Drug	Allergic Reaction

Name: _____

Family Medical History

Please list any medical conditions in your family:

Relationship to Patient	Living/Deceased	Age	Medical Conditions
Mother			
Father			
Grandmother			
Grandfather			
Brother			
Sister			

Social History

Occupation	
Physical requirements of your job	
Marital Status	
Number of Children	

Tobacco Use Please Circle One		
Never	**Current**	**Former**

Amount Used	
Age Started	
Age Stopped	

Alcohol Use Please Circle One		
Never	**Current**	**Former**

Amount Used	
Age Started	
Age Stopped	

Recreational Drug Use Please Circle One		
Never	**Current**	**Former**

Amount Used	
Age Started	
Age Stopped	

Name: _____

Review of Systems

Are you ***currently*** experiencing any of the following?

(Please circle all that apply)

General	fatigue, fever, chills, body aches, weight loss, weight gain, loss of appetite
Eyes	double vision, blurred vision, peripheral vision changes, changes in vision, sudden visual loss, central vision changes, wears glasses/contacts for vision correction
Head/Ears/Nose/Throat	headaches, vertigo, lightheadedness, recent head injury, neck stiffness, neck pain, sinus problems, hearing loss, ringing in ears, hoarseness, difficulty swallowing, voice changes
Cardiovascular	chest pain, irregular heartbeats, lower extremity edema
Respiratory	shortness of breath, wheezing, cough, sleep apnea
Gastrointestinal	nausea, vomiting, diarrhea, constipation, abdominal pain, rectal incontinence
Genitourinary	incontinence, painful urination, frequent urination, urinary retention
Skin	rash, itching, new skin lesions
Neurologic	muscular weakness, incoordination, tingling/numbness, falls, memory difficulties, speech difficulties, seizures, loss of balance
Musculoskeletal	joint pain, joint swelling, muscle pain, limitation of motion, muscular weakness, muscle cramps, back pain, gait disturbance, restless legs, extremity pain
Endocrine	excessive urination, excessive thirst, nipple discharge, enlarged hands and feet, enlarged facial features
Psychiatric	anxiety, depression, hallucinations, difficulty sleeping
Hematologic	easy bleeding, easy bruising, previous blood transfusion
Allergic/Immune	sinus allergy symptoms, latex allergy

Name: _____

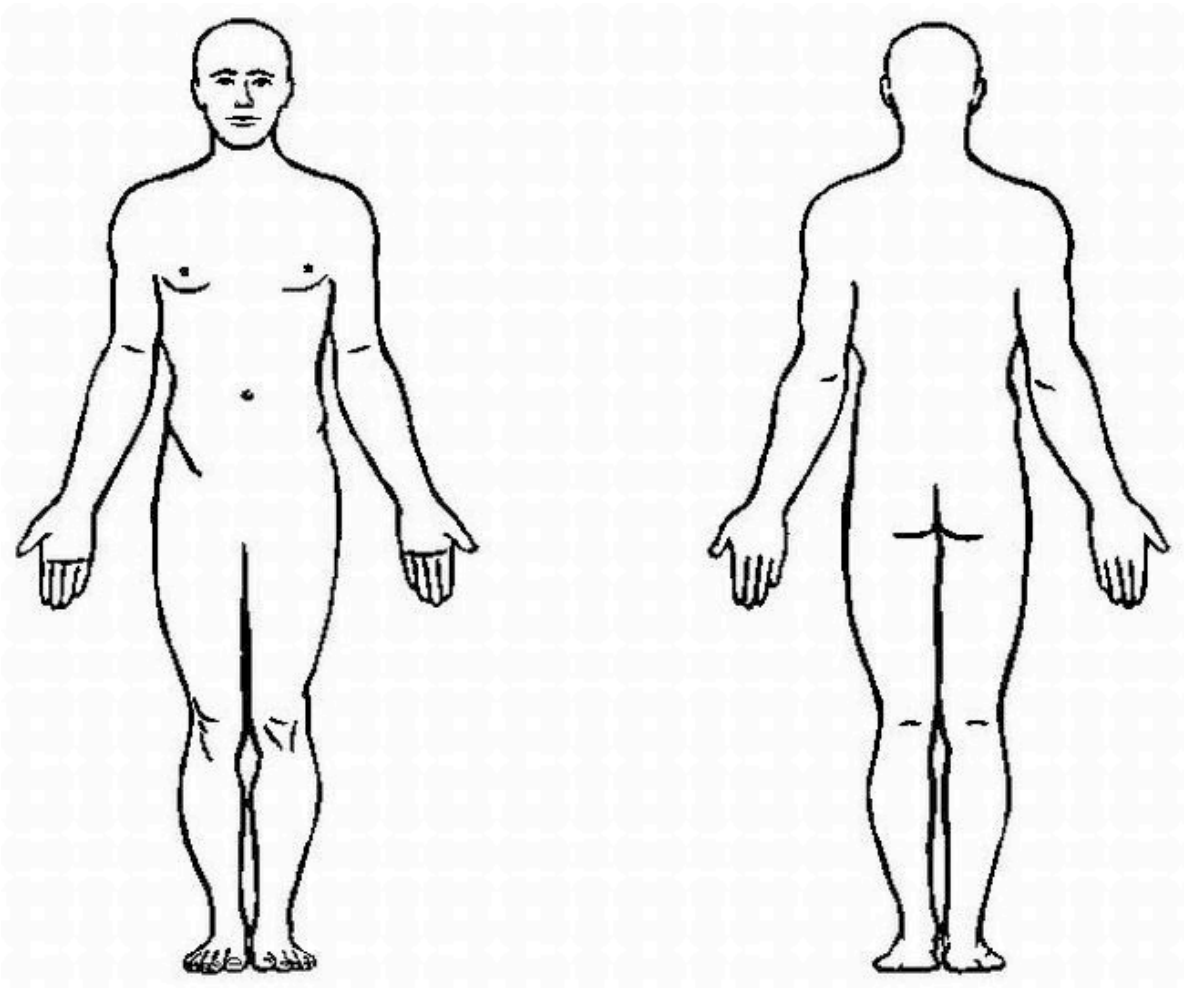
Hand Preference

Please Circle Your Hand Preference	Right	Left	Ambidextrous

Pain Diagram

Please indicate the location of the pain on the chart below using the following symbols:

Numbness _____ Burning XXXX Pins and Needles //// Aching ||||



How did you first hear about Dallas Neurosurgical?

Internet / DNS Website	
Mass Media (i.e. magazine, newspaper, radio)	
Family Member	
Friend or Colleague	
Referring physician	
Other (please describe): _____	