



SECTION OF NEUROSURGERY
PATIENT INFORMATION SHEET

EC#: (for office use only)

Patient's Name: Today's Date:

Age: Date of Birth: Height: Weight:

Physician you are seeing today:

Marital Status: Married, Divorced, Separated, Widowed, Single
Work Status: Employed as: Workers' Compensation, Retired, Disabled, Unemployed

General Health Status: Excellent, Good, Fair, Poor
Are You: Right-Handed, Left-Handed

Please list all the physicians you are currently seeing and/or whom you want to be informed about your progress:

Physician who referred you: Name: Address: Telephone: Fax:

Your Family Physician: Name: Address: Telephone: Fax:

Other Physician: Name: Address: Telephone: Fax:

1. Please describe the type of medical problem or symptoms that you are being seen for today:

2. Were you injured at work? Were you injured in a motor vehicle accident? If yes, explain:

Date of Injury: Date you last worked:

Attorney's Name and Address:

3. Do you now or have you ever had the following:

- | | | | | | |
|---------------------|------------------------------|-----------------------------|------------------------------------------------------|------------------------------|-----------------------------|
| Heart problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes or problems with blood sugar | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lung problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | GI problems (i.e., ulcers, hiatal hernia, gastritis) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver disease (such as hepatitis) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Problems with blood (i.e., clotting problems) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | | | Any type of cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Other: _____

4. Please list all surgeries you have had, including the year they were performed: _____

5. Have you ever had radiation therapy? Yes No

Have you ever had chemotherapy? Yes No

Please list the date(s) and the facility where you were treated: _____

6. Please list any medications you are currently taking. List the name of the medication, the frequency, and the dosage: _____

7. Are you allergic to any medications? Please list the name of the medication and the reaction caused by taking the medication.

8. Have you ever had a reaction to any dye given for a special test? If so, what was the test, and what kind of reaction did you have? _____

9. Do you use:

A. Tobacco	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How much per day? _____
B. Alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How much per day? _____
C. Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How much per day? _____

10. Are you on a special diet? If so, please specify the type of diet. _____

11. How many hours of sleep per night do you get on average? _____ hours.

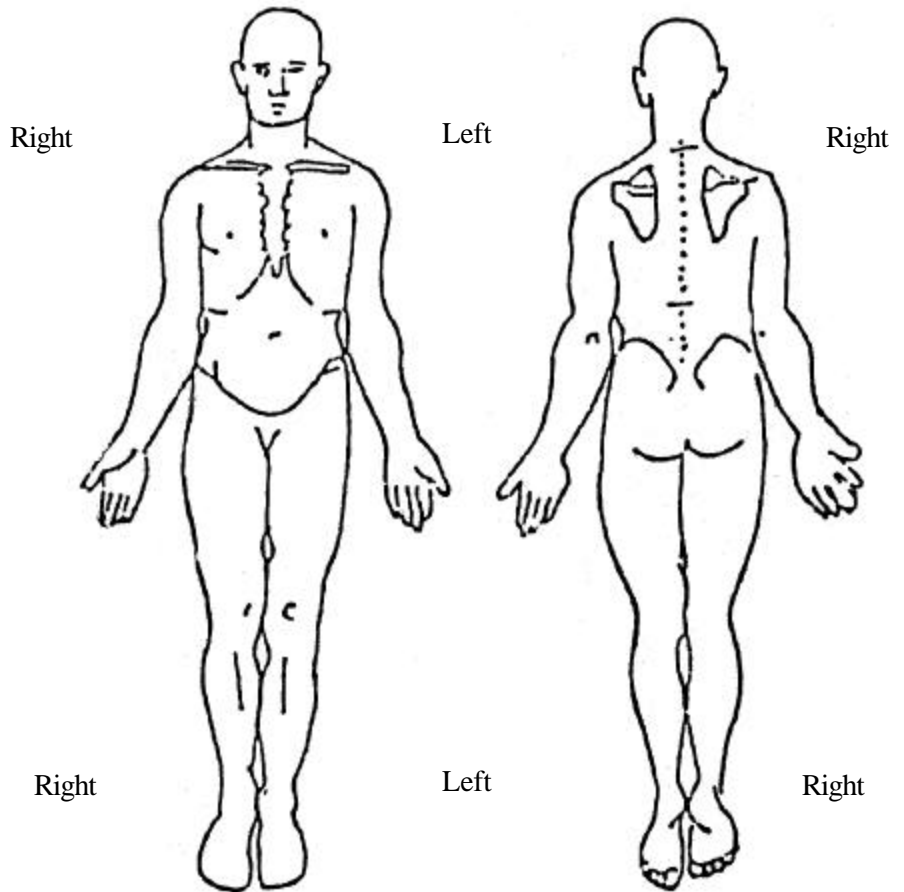
12. Is there other information about yourself that you would like for us to know? _____

13. Has anyone in your immediate family had:

- | | | | |
|------------------------|------------------------------|-----------------------------|-------------------|
| A. High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If so, who? _____ |
| B. Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If so, who? _____ |
| C. Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If so, who? _____ |
| D. Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If so, who? _____ |
| E. Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If so, who? _____ |
| F. Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If so, who? _____ |
| G. Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If so, who? _____ |
| H. Migraine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If so, who? _____ |

I. Other (please list): _____

If you have pain, numbness, or tingling, please complete the following:



Please indicate with an "X" or "O" on the accompanying diagrams the location of your symptoms.

X = Pain

- | | | |
|--------------------------|--------------|----------------|
| Severity (if applicable) | Description | |
| _____ Constant | _____ Aches | _____ Tingles |
| _____ Occasional | _____ Throbs | _____ Stabbing |
| _____ Wakes you up | _____ Burns | _____ Numbness |
| _____ Difficulty walking | | |

Indicate current level of pain on the following scale:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Intolerable

What makes your condition worse? _____

What helps your condition? _____

Other body parts affected: _____

Symptoms affected by: _____

What kind of effect do the following activities have on your symptoms?

	Sitting	Standing	Exercise	Rest
Increase				
Decrease				