NSPC
Brain & Spine
Surgery

NEUROLOGICAL SURGERY, P.C.

PATIENT INFORMATION

Name _____ Date of Birth _____ Age _____

Address _____ City _____ Sate NY Zip _____

Home (_____) _____-_____ Cell (___) _____-_____ Work (___) _____-_____ Ext: ___

Email Address _____

Sex ☐M ☐F Soc. Sec. #: _____/____/_____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Occupation _____ Employer _____

Employer's Address _____

Referred By _____ Phone: ( ) _____

Address _____

Primary Care Physician _____ Phone: ( ) _____

Address: _____

Preferred Pharmacy Name _____ Phone _____ Fax _____

Pharmacy Address: _____

Emergency Contact/Relationship _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance _____

Policy Holder's Name _____ ID#_____

Policy Holder's Birth Date _____ Policy Holder's SS# _____

Secondary Insurance _____ Relationship _____

Policy Holder's Name _____ ID# _____

Birth Date _____ SS#:_____ Group # _____

WORKER'S COMPENSATION or **NO FAULT**: *please circle one*

Insurance Company _____ **DATE OF ACCIDENT** _____

Address _____

Policy Number _____ Carrier Case # _____

Case Manager _____ Phone: ( ) _____ Ext: _____

MEDICAL HISTORY

PLEASE COMPLETE FORMS CAREFULLY

MAKE SURE TO ANSWER **ALL** QUESTIONS. **SIGN AND DATE EACH PLACE INDICATED**. THANK YOU.

NAME DATE

I. **What is the main complaint for which you are coming to this office**?

_____

_____

II. **What is the history of your present illness**? (If you require additional space, please use back of page.)

a. When did the problem start? _____
b. Where is the problem located? _____

c. Has it become worse? _____ better? _____ same? _____

d. If you have pain, does the pain travel? _____ where to? _____

e. Is the problem constant? _____

f. If the problem is on and off, is it ____ daily? ____ weekly? ____ monthly? ____ other?

g. What, if anything, makes it better?
_____ _____

h. What, if anything makes it worse?
_____

i. What treatments have you had for this problem?

_____

_____

_____

j. Are there any other problems associated with your main problem?
☐ headache ☐ vision ☐ speech ☐ numbness
☐ dizziness ☐ hearing ☐ pain ☐ weakness

III. FAMILY HISTORY

A. Check the condition, and which family member has the condition (i.e. mother, father, brother, sister, son, daughter, etc.)

☐ Arthritis _____ ☐ Allergy _____ ☐ Gout _____
☐ Cancer _____ ☐ Diabetes _____ ☐ Jaundice _____
☐ Psychosis _____ ☐ Ulcer _____ ☐ Coronary Disease _____
☐ Epilepsy _____ ☐ Rheumatic Heart Disease _____ ☐ Hypertension _____
☐ Gall Bladder Stones _____ ☐ Tuberculosis _____ ☐ Bleeding Tendency _____
☐ Thyroid_____ ☐ Nervous Breakdown _____ ☐ Kidney Stones _____
☐ Kidney Disease _____ ☐ Leukemia or Lymphoma _____

B. Mother ☐ Living ☐Died at age _____ cause _____
C. Father ☐ Living ☐Died at age _____ cause _____

MEDICAL HISTORY

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MAKE SURE TO ANSWER **ALL** QUESTIONS. **SIGN AND DATE EACH PLACE INDICATED**. THANK YOU.

NAME DATE

IV. HABITS

	AMOUNT	HOW LONG	WHEN CHANGED
◆ Alcohol			
◆ Tobacco			

• Height: _____ • Weight: _____ lbs Gain _____ Loss _____

• Sleep _____ hours • Eating Habits: ☐ Good ☐ Poor

V. CURRENT MEDICATIONS (attach a list or write below with does and times per day)

MEDICATION	DOSE	TIMES PER DAY	MEDICATION	DOSE	TIMES PER DAY

VI. SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed how long? _____

Present Occupation: _____ How long? _____

Prior Work: _____

Exposure to Occupational Disease: ☐ Yes ☐ No When _____

Travel _____

VII. PREVIOUS HEALTH AND ILLNESS

A. General Health

1. Recent examinations and hospitalizations: _____
2. Past medical illnesses: _____

   _____
3. Past Surgeries:_____

   _____
4. Radiation Therapy: _____
5. Last Tetanus Booster: _____
6. Transfusions: date: _____ amount: _____ reactions: _____
7. Have you ever had a Tumor or Cancer? Where and when? _____

MEDICAL HISTORY

PLEASE COMPLETE FORMS CAREFULLY

MAKE SURE TO ANSWER **ALL** QUESTIONS. **SIGN AND DATE EACH PLACE INDICATED**. THANK YOU.

NAME DATE

VII. PREVIOUS HEALTH AND ILLNESS (continued)

B. Review of Systems (check and explain in # 11)

1. **ALLERGIES**: ☐ Asthma ☐ Food ☐ Hayfever ☐ Urticaria ☐ Inhalants
   ☐ Penicillin ☐ Drugs ☐ NONE ☐ AMBIEN

2. **HEAD**: ☐ Headache ☐ Visual Disturbance ☐ Dental Disease ☐ Sinusitis
   ☐ Earache ☐ Bleeding Gums ☐ Head Injury ☐ Tinnitus
   ☐ Upper Respiratory Infection ☐ Hearing Disturbance ☐ Nose Bleed ☐ NONE

3. **RESPIRATORY TRACT**: ☐ Pleurisy ☐ Sputum ☐ Hoarse ☐Wheezing
   ☐ Hiccups ☐ Pneumonia ☐ Bronchitis ☐ TB
   ☐ Chronic Cough ☐ Spitting up Blood ☐ Other _____
   ☐ NONE ☐ Last Chest X-Ray _____

4. **CARDIAC**: ☐ Angina ☐ Hypertension (high blood pressure) ☐ Arrhythmia
   ☐ Cyanosis ☐ Heart Murmur ☐ Palpitations ☐ Edema
   ☐ Dyspnea (difficulty breathing) ☐ Enlarged Heart
   ☐ Nocturnal Dyspnea (difficulty breathing at night) ☐NONE
   ☐ Last EKG _____
   ☐ Special Diagnostic Tests _____ Results _____

5. **GI** (Gastro-intestinal): ☐ Dysphagia (difficulty swallowing) ☐ Anorexia
   ☐ Bowel Habit Change ☐ Nausea ☐ Cramps
   ☐ Eructation (belching) ☐ Constipation ☐ Jaundice
   ☐ Hemorrhoids ☐ Heartburn ☐ Diarrhea
   ☐ Abdominal Pain ☐Indigestion ☐Hernia
   ☐ Hematemesis (vomiting blood) ☐ Black or Bloody Stool
   ☐ NONE ☐ Other: _____

6. **GU** (Genito-urinary):
   a. Male/female ☐ Dysuria (difficulty urinating) ☐ Hematuria (blood in urine)
   ☐ Facial Edema (swelling) ☐ VD (venereal disease)
   ☐ Nocturia (urinating at night) ☐ Urinary retention
   ☐ Frequency ☐ Back Pain ☐ Stones
   ☐ NONE ☐ Other: _____

   b. Female ☐ Menarche ☐ Menses Regular ☐ LMP
   ☐ Abnormal Bleeding ☐ Last Pap Smear _____
   ☐ Post-menopausal bleeding ☐ Number of pregnancies _____
   ☐ Abortions _____ ☐ Number of children _____
   ☐ Other: _____

MEDICAL HISTORY

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NAME DATE

7. **Neuro-Muscular**:
☐ Dizziness ☐ Abnormal Gait ☐ Memory Problems
☐ Syncope ☐ Unconsciousness ☐ Weak Spell
☐ Vertigo ☐ Paresthesias (abnormal sensations)
☐ Joint Pain ☐ Convulsions ☐Tremor
☐ Arthritis ☐ NONE ☐ Other: _____

8. **Emotional**:
☐ Personality Change ☐ Nervous Breakdown
☐ Depressed ☐ Psychiatric Treatment
☐ NONE ☐ Other: _____

9. **Do you have**
☐ DIABETES?
☐ PACEMAKER?
☐ DEFIBRILLATOR?

10. Symptoms or Diseases not listed: _____

☐ NONE

11. Explanation of checked items:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

☛ _____ Date: _____

Patients Signature