NSPC
Brain & Spine
Surgery

MEDICAL HISTORY

PLEASE COMPLETE FORMS CAREFULLY

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

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.)

Condition	Family Member	Condition	Family Member	Condition	Family Member
Arthritis		Allergies		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/ Lymphoma		Other: (specify)	

B. Mother ☐ Living ☐ Deceased (at age) _____ cause: _____

C. Father ☐ Living ☐ Deceased (at age) _____ cause: _____

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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 doses and times per day)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

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 (if any): _____
7. Have you ever had a tumor or cancer? Where and when? _____

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VIII. 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 ☐ Hemorrhoids ☐ Diarrhea

☐ Bowel Habit Change ☐ Nausea ☐ Cramps ☐ Heartburn ☐ Abdominal Pain

☐ Erucation (belching) ☐ Constipation ☐ Cramps ☐ Indigestion ☐ Hernia

☐ Hematemesis (vomiting blood) ☐ Black or blood 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 ☐ Post Menopausal Bleeding

Last Pap Smear # of Pregnancies: _____ Abortions Y or N #: _____

# of children: _____

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7. NEURO- MUSCUAR:
   - ☐ 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 ANY OF THE FOLLOWING:
   - ☐ DIABETES
   - ☐ PACEMAKER
   - ☐ DEFRIBRILLATOR

10. SYMPTOMS OR DISEASES NOT LISTED?

_____

_____

☐ NONE

11. EXPLAINATION OF CHECKED ITEMS:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

PATIENT'S SIGNATURE DATE

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To provide you with the best patient care, NSPC would like to share all medical notes from this visit with your current treating physicians. Please provide the following information:

Doctor's Name	Doctor's Specialty	Doctor's Address	Doctor's Phone Number