GREAT LAKES SURGERY AND NEUROINTERVENTION

Patient History
PLEASE COMPLETE ALL CATEGORIES IN BLUE OR BLACK INK

Patient Name ____Date of Birth________________ page 1 of 3

Age:_______ Sex ☐ Male ☐ Female Height _________ Weight _________

Occupation:_____________________________ How Long? __________________

Referring Physician_________________________________ Family Physician_____________________________

IF YOUR SYMPTOMS ARE A RESULT OF AN INJURY, COMPLETE THE FOLLOWING:

Type of injury: ☐ Work ☐Auto ☐Home ☐ Other (Explain)____

Date of Injury?:_____/_____/____ Where it happened:____

How it happened:____

Are you currently off work due to this injury?: ____________ If yes, as of what date?:_____/_____/_____

HISTORY OF PRESENT ILLNESS

Date your symptoms began:_____/_____/_____

Describe your symptoms:____

____

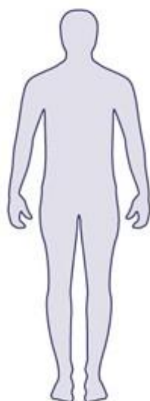
____

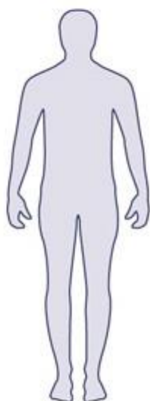
Is your pain (circle all that apply): Sharp Dull Aching Stabbing Burning Tingling Numb

Severity: Rate 1(low) to 10 (high) _______ Have you had any loss of bowel or bladder control?___________

When do you have pain? (circle one) Constantly Daily Weekly Monthly Other________________________

Please mark the areas on your body where you feel the following sensations, using symbols below:
(*) NUMBNESS (+) PINS/NEEDLES (X) BURNING (/) STABBING





What makes it worse?_________________________

____

____

____

What makes it better?_________________________

____

____

____

GREAT LAKES NEUROSURGERY AND NEUROINTERVENTION

PLEASE COMPLETE ALL CATEGORIES

Patient Name____ Date of Birth_____/_____/_____ Page 2 of 3

What treatment have you had for your complaints?
Physical Therapy_____ Brace/Collar/Splint_____ TENS Unit_____ Pain Clinic_____
Chiropractor_____ Chiropractor_____ Injections/Blocks_____
Treatment by Another Doctor____
Medications (please list)____

SOCIAL HISTORY
Single_____ Married_____ Divorced_____ Widow(ed)_____
Current Smoker ☐ Yes ☐No Were you ever?___________ Packs per day__________ Years_____
Alcohol_____ drinks per week Currently use recreational drugs ☐Yes ☐ No

FAMILY HISTORY
Do any family members suffer from the following conditions? ☐ Yes ☐ No If so who?
Heart____________________________ Diabetes ______________________________
Cancer___________________________ Stroke ________________________________
Hypertension______________________ Aneurysm____________________________

PAST MEDICAL HISTORY
Do you suffer from the following conditions?
Cardiac: Heart Attack ☐ Yes ☐ No Abnormal Rhythm ☐ Yes ☐ No Murmur ☐ Yes ☐ No Other ☐ Yes ☐ No ___________________
Pulmonary: Asthma ☐ Yes ☐ No COPD ☐ Yes ☐ No Emphysema ☐ Yes ☐ No Other ☐ Yes ☐ No ___________________
Endocrine: Diabetes ☐ Yes ☐ No Hypothyroid ☐ Yes ☐ No Pituitary Tumor ☐ Yes ☐ No Other ☐ Yes ☐ No ___________________
Circulatory: Hypertension ☐ Yes ☐ No Stroke ☐ Yes ☐ No Aneurysm ☐ Yes ☐ No Other ☐ Yes ☐ No ___________________
Bleeding Disorders ☐ Yes ☐ No
Cancer: Type____ Date of Diagnosis:______________________________

Other:____

____

REVIEW OF SYSTEMS **Physician Notes**

Neurological	Headache	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No		____________________
	Memory Loss	☐ Yes ☐ No	Numbness	☐ Yes ☐ No		____________________
Eyes	Glasses	☐ Yes ☐ No	Contacts	☐ Yes ☐ No		____________________
	Blurriness	☐ Yes ☐ No	Double Vision	☐ Yes ☐ No		____________________
Ears/Throat	Deafness	☐ Yes ☐ No	Ringing	☐ Yes ☐ No		____________________
	Swallowing	☐ Yes ☐ No	Hoarseness	☐ Yes ☐ No		____________________
Cardiac	Chest Pain	☐ Yes ☐ No	Irregular Beats	☐ Yes ☐ No		____________________
	Raid Beat	☐ Yes ☐ No	Edema	☐ Yes ☐ No		____________________
Pulmonary	Cough	☐ Yes ☐ No	Cough Blood	☐ Yes ☐ No		____________________
	Wheezing	☐ Yes ☐ No	Short of Breath	☐ Yes ☐ No		____________________
Intestinal	Constipation	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No		____________________
	Incontinence	☐ Yes ☐ No	Bleeding	☐ Yes ☐ No		____________________
Urinary	Frequency	☐ Yes ☐ No	Burning	☐ Yes ☐ No		____________________
	Incontinence	☐ Yes ☐ No	Bleeding	☐ Yes ☐ No		____________________
Musculoskeletal	Pain	☐ Yes ☐ No	Weakness	☐ Yes ☐ No		____________________
	Arthritis	☐ Yes ☐ No	Cane/Walker	☐ Yes ☐ No		____________________
Endocrine	Weight Loss	☐ Yes ☐ No	Weight Gain	☐ Yes ☐ No		____________________
	Heat Intolerance	☐ Yes ☐ No	Cold Intolerance	☐ Yes ☐ No		____________________
Skin	Bruising	☐ Yes ☐ No	Lesions	☐ Yes ☐ No		____________________
	Birth Marks	☐ Yes ☐ No				____________________
Hematological	Bleeding	☐ Yes ☐ No	Transfusions	☐ Yes ☐ No		____________________
	Hepatitis	☐ Yes ☐ No				____________________
Psychiatric	Depression	☐ Yes ☐ No	Fatigability	☐ Yes ☐ No		____________________
	Insomnia	☐ Yes ☐ No				____________________

Great Lakes Neurosurgery and Neurointervention

PLEASE COMPLETE ALL CATEGORIES

Patients Name____Date of Birth______________________

PATIENT'S PREVIOUS SURGERIES: (List type, date, surgeon)
Brain or Spine Surgery:____
____

Other Surgery:____
____

ALLERGIES: (Include type of reaction and allergies to shell fish or iodine):
____
____
____
____

CURRENT MEDICATIONS: (List dosage, frequency, duration) Attach additional page if needed. Please include everything you take, such as over the-the counter medications (i.e. asprin, ibuprofen), vitamins and herbal supplements.

____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________

DIAGNOSTIC STUDIES: Please list the date and place your study was done. You must bring reports on all studies (check with your referring physician). On the (*) studies, you must bring actual films as well.

X-Rays*_________________________________
MRI*___________________________________
CT Scan*________________________________
EEG____________________________________
EMG/NCV_______________________________
Tomogram*______________________________
Myleogram*_____________________________
Bone Scan______________________________
Evoked Response_________________________
OTHER_________________________________

Patient Signature____ **Date**_______/_________/_________

(DRS USE ONLY) I personally reviewed all of the systems noted on page two of this Patient History with the patient. All are negative except where indicated .
First Consultation/Visit: MD Initials _________ Date _____/_____/_____ Scribed by_____________________________________

□ Change □ No Change MD initials__________ Date_____/_____/_____ Scribed by_____________________________________

Notes:____

□ Change □ No Change MD initials __________ Date_____/____/______ Scribed by _____________________________________

Notes:____

□ Change □ No Change MD initials __________ Date_____/____/______ Scribed by _____________________________________

Notes:____

□ Change □ No Change MD initials __________ Date_____/____/______ Scribed by _____________________________________

Notes:____

□ Change □ No Change MD initials __________ Date_____/____/______ Scribed by _____________________________________

Notes:____