Surgery/NeuroSurgery

PATIENT HISTORY FORM

Reason for visit: _____

Date of visit: _____

Referring Physician: _____
Address: _____
_____
_____

Patient Medical History

Previous Hospitalizations/Surgeries/Serious Injuries:

Current Prescription and Over the Counter Medications:

Any Known Drug Allergies? _____ *Type of reaction:* _____

Date of last Immunization: Tetanus _____ Hep B Series _____
Flu Shot _____ PPD (TB Test) _____

Patient Social History

(please circle one)	Male	Female			
Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	
Use of Tobacco:	Never	Previously, but quit		Current, packs/day _____	
Use of Drugs:	Never	Type/Frequency: _____			

Occupation: _____

Family Medical History

	Age	Any Disease/Conditions Past/Present	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Review of Systems *(please circle any of the listed symptoms that are current or past problems for you)*

Constitutional:	Fever	Chills	Weight loss or gain	Fatigue
Eyes:	Double Vision	Blurry Vision	Need for glasses	Glaucoma Injury or surgery
Ear, Nose, Throat:	Sinusitis	Hearing Loss	Ringing in Ears	Sores Voice change Swelling
Cardiovascular:	Heart attack	Chest Pain	High Blood pressure	Palpitations Leg Swelling
Respiratory:	Shortness of breath	Asthma	Cough	Spitting up blood Wheezing
Gastrointestinal:	Loss of appetite	Nausea	Vomiting	Abnormal bowel movements Pain
Genitourinary:	Frequent or painful urination		Incontinence	Infections Irregular menses
Musculoskeletal:	Joint pain or stiffness		Weakness	Injury or surgery Swelling
Skin/Breast	Rashes	Ulcers	Nail Changes	Breast pain or lump Or discharge
Neurological:	Stroke or TIA	Headaches	Dizziness	Seizures Loss of Balance
Psychological:	Memory Loss	Depression	Insomnia	Nervousness
Endocrine:	Diabetes	Thyroid problem		Excessive thirst or urination
Hematologic:	Bleeding or bruising tendency		Phlebitis	DVT Transfusion
Infection:	Hepatitis A B C		HIV/AIDS	

Other Pertinent ROS

Patient's Signature: _____ ***Physician's Signature:*** _____