

Dallas Neurosurgical and Spine Associates, P.A

Patient Health History

Name: _____ DOB: _____ Date: _____

Reason for your visit (Chief complaint): _____

Past Medical History

Please check corresponding box if you have ever had any of the following medical conditions:

Heart Problems	
Congestive Heart Failure	<input type="checkbox"/>
Deep Vein Thrombosis	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>
Irregular Heartbeat (Atrial Fibrillation)	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

Lung Problems	
Asthma	<input type="checkbox"/>
Chronic Obstructive Pulmonary Disease	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>
Pulmonary Embolism	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

Gastrointestinal Problems	
Cirrhosis	<input type="checkbox"/>
Gastric ulcer	<input type="checkbox"/>
Gastroesophageal Reflux Disease	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>
Rectal bleeding	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

Endocrine Problems	
Diabetes, Type I (Juvenile Onset)	<input type="checkbox"/>
Diabetes, Type II (Adult Onset)	<input type="checkbox"/>
Thyroid disorder – Type: _____	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

Musculoskeletal	
Fibromyalgia	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

Neurological	
Alzheimer's Disease	<input type="checkbox"/>
Cerebral Aneurysm	<input type="checkbox"/>
Closed Head Injury	<input type="checkbox"/>
Essential Tremor	<input type="checkbox"/>
Hydrocephalus	<input type="checkbox"/>
Migraines	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>
Peripheral Neuropathy	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>
Stroke	<input type="checkbox"/>
TIA	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

Urinary Problems	
Kidney Infection (pyelonephritis)	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>
Prostate enlargement	<input type="checkbox"/>
Urinary Tract Infection	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

Blood Disorders	
Anemia	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>
HIV +	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

Cancer	
Type: _____	<input type="checkbox"/>
Type: _____	<input type="checkbox"/>

Anesthesia	
Have you ever had a reaction to anesthesia?	<input type="checkbox"/>
Please Describe: _____	<input type="checkbox"/>

Other: _____	<input type="checkbox"/>
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Family Medical History

Please list any medical conditions in your family:

Relationship to Patient	Living/Deceased	Age	Medical Conditions
Mother			
Father			
Grandmother			
Grandfather			
Brother			
Sister			

Social History

Occupation	
Physical requirements of your job	
Marital Status	
Number of Children	

Tobacco Use Please Circle One		
Never	Current	Former

Amount Used	
Age Started	
Age Stopped	

Alcohol Use Please Circle One		
Never	Current	Former

Amount Used	
Age Started	
Age Stopped	

Recreational Drug Use Please Circle One		
Never	Current	Former

Amount Used	
Age Started	
Age Stopped	

Review of Systems

Are you **currently** experiencing any of the following?

(Please circle all that apply)

General	fatigue, fever, chills, body aches, weight loss, weight gain, loss of appetite
Eyes	double vision, blurred vision, peripheral vision changes, changes in vision, sudden visual loss, central vision changes, wears glasses/contacts for vision correction
Head/Ears/Nose/Throat	headaches, vertigo, lightheadedness, recent head injury, neck stiffness, neck pain, sinus problems, hearing loss, ringing in ears, hoarseness, difficulty swallowing, voice changes
Cardiovascular	chest pain, irregular heartbeats, lower extremity edema
Respiratory	shortness of breath, wheezing, cough, sleep apnea
Gastrointestinal	nausea, vomiting, diarrhea, constipation, abdominal pain, rectal incontinence
Genitourinary	incontinence, painful urination, frequent urination, urinary retention
Skin	rash, itching, new skin lesions
Neurologic	muscular weakness, incoordination, tingling/numbness, falls, memory difficulties, speech difficulties, seizures, loss of balance
Musculoskeletal	joint pain, joint swelling, muscle pain, limitation of motion, muscular weakness, muscle cramps, back pain, gait disturbance, restless legs, extremity pain
Endocrine	excessive urination, excessive thirst, nipple discharge, enlarged hands and feet, enlarged facial features
Psychiatric	anxiety, depression, hallucinations, difficulty sleeping
Hematologic	easy bleeding, easy bruising, previous blood transfusion
Allergic/Immune	sinus allergy symptoms, latex allergy

Hand Preference

Please Circle Your Hand Preference	Right	Left	Ambidextrous
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Pain Diagram

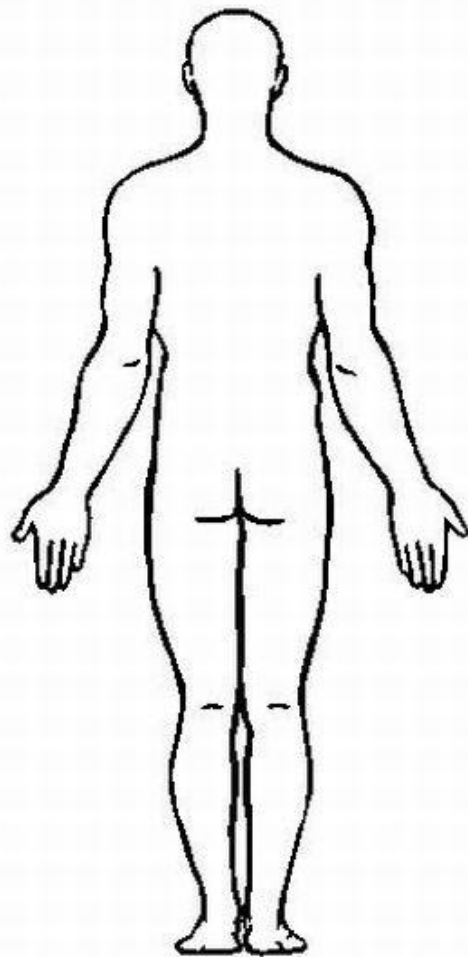
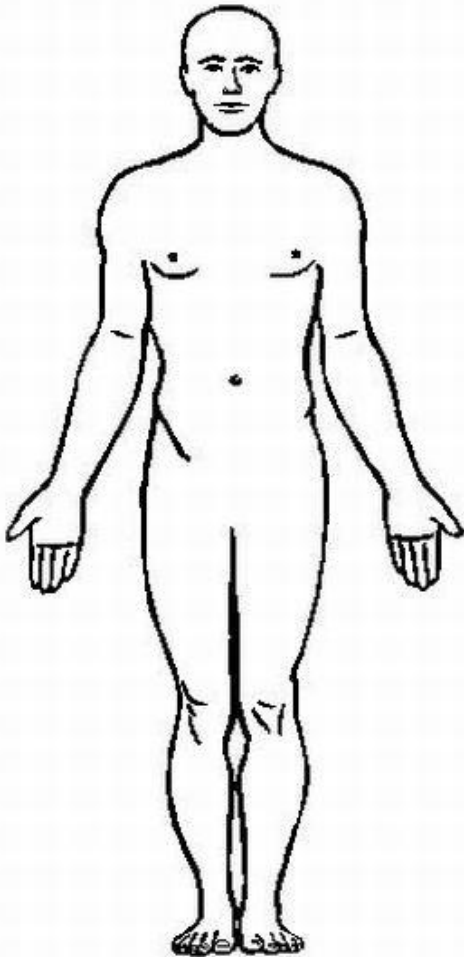
Please indicate the location of the pain on the chart below using the following symbols:

Numbness _____

Burning XXXX

Pins and Needles ////

Aching ||||



How did you first hear about Dallas Neurosurgical?

Internet / DNS Website	
Mass Media (i.e. magazine, newspaper, radio)	
Family Member	
Friend or Colleague	
Referring physician	
Other (please describe): _____	