NEUROSURGERY HEALTH QUESTIONNAIRE

Patient Name _____ Patient Date of Birth _____ Age _____ Today's Date _____

Name of Referring Doctor _____ Name of Primary Care Provider _____

Patient Email Address _____ Preferred Pharmacy _____

Preferred Lab _____ Preferred Imaging Center _____

CHIEF COMPLAINT(S) AND DATE SYMPTOMS STARTED_____

_____

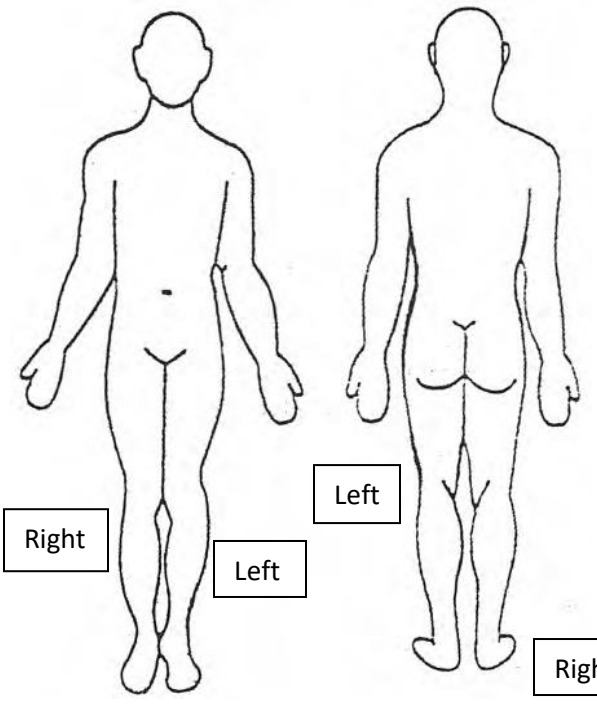
IF INJURY, HOW DID INJURY OCCUR?_____

HEIGHT_____ WEIGHT_____

TREATMENT FOR CURRENT SYMPTOMS	DATE	TREATMENT FOR CURRENT SYMPTOMS	DATE
☐ Epidural Injections	_____	☐ Chiropractic	_____
☐ Facet Blocks	_____	☐ Bracing	_____
☐ Physical Therapy	_____	☐ Other	_____

LIST ANY PAST SURGERIES	DATE	LIST CURRENT MEDICATIONS / DOSAGES	TIMES PER DAY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ON THE DIAGRAM, SHADE THE AREA WJHERE YOU FEEL PAIN. PUT AN X IN THE AREA THAT HURTS THE MOST.



DO YOU SMOKE? ☐ Yes, Amount_____ ☐ No
FORMER SMOKER? ☐ Yes ☐ No HOW LONG DID YOU SMOKE? _____
DO YOU CONSUME ALCOHOL? ☐ Yes ☐ No AMOUNT_____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐ Yes ☐ No

LIST ANY OTHER MEDICAL PROBLEMS

_____
_____

LIST ANY ALLERGIES

_____
_____

Do you have religious beliefs that influence your medical decisions? ☐ Yes ☐ No
Do you have someone who loves and cares for you? ☐ Yes ☐ No ☐ Not Sure
Do you have a source of joy in your life? ☐ Yes ☐ No ☐ Not Sure
Do you have a sense of peace today? ☐ Yes ☐ No ☐ Not Sure

NEUROSURGERY HEALTH QUESTIONNAIRE

CHECK ANY PAST ILLNESSES

- ☐ Cancer
- ☐ Asthma
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Bronchitis
- ☐ Rheumatic Fever
- ☐ Kidney Problems
- ☐ Stroke
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Drug Problem
- ☐ Epilepsy
- ☐ Pancreatitis
- ☐ Thyroid Problem
- ☐ Clotting Problems
- ☐ Liver Problems

FAMILY HEALTH HISTORY

MOTHER

- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke

FATHER

- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke

GRANDMOTHER (Please indicate Maternal or Paternal)

- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke

GRANDFATHER (Please indicate Maternal or Paternal)

- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke

SISTER

- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke

BROTHER

- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke