Neurosurgery Established Patient Questionnaire

Name: _____**Date:** _____

Primary Care Physician: _____

Phone: _____ **Fax:** _____

Referring Physician: _____

Phone: _____ **Fax:** _____

Are there any other Physicians you would like today's office note sent to:

Name: _____ Fax: _____

Name: _____ Fax: _____

Name: _____ Fax: _____

Name: _____ Fax: _____

Name: _____ Fax: _____

Name: _____ Fax: _____

What is the problem you are here for today? _____

Pharmacy name: _____

Address: _____

Fax: _____

Tobacco History (Please check one that applies):

Are you a: Current smoker?_____ Former smoker?_____ Not a smoker? _____

If you are a current smoker:

How often do you smoke? Every day _____Some days _____Frequency unknown _____ unknown _____

Please Choose A Number From 0 To 10 That Best Describes Your Pain