Neurosurgery Initial Patient Questionnaire

To Our Patients:
If you are seeing one of our physicians for the first time, we would appreciate you answering the following questions. This will give us a clearer picture of your overall health and allow your doctor to help you better with your neurosurgical problem.

Name: ____________________________ Date: ____________________________

Age: __________ Height: __________ Weight: __________

**Past Medical History:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Attack</td>
<td></td>
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<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
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<tr>
<td>Stroke</td>
<td></td>
<td></td>
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<tr>
<td>Asthma</td>
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<td></td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Emphysema</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Liver Disease</td>
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<tr>
<td>Blood Clots</td>
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<tr>
<td>Kidney Disease</td>
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<tr>
<td>Bleeding Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
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</tr>
</tbody>
</table>

**Surgical History and Dates**

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

**Allergies**

Medication Allergies: _________________________________________________________________

Other Allergies: _________________________________________________________________

**Family History**

<table>
<thead>
<tr>
<th>Family</th>
<th>Alive?</th>
<th>Age?</th>
<th>Health problems or cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>______</td>
<td>_____</td>
<td>_________</td>
</tr>
<tr>
<td>Father</td>
<td>______</td>
<td>_____</td>
<td>_________</td>
</tr>
<tr>
<td>Sister(s)</td>
<td>______</td>
<td>_____</td>
<td>_________</td>
</tr>
<tr>
<td>Brother(s)</td>
<td>______</td>
<td>_____</td>
<td>_________</td>
</tr>
<tr>
<td>Daughter(s)</td>
<td>______</td>
<td>_____</td>
<td>_________</td>
</tr>
<tr>
<td>Son(s)</td>
<td>______</td>
<td>_____</td>
<td>_________</td>
</tr>
</tbody>
</table>

Any other diseases in family? _________________________________________________________

**Personal History**

Highest level of education: __________________________________________________________

Occupation: ________________________________

Do you drink alcoholic beverages? If so, how many drinks per week? _____________________

Have you used any drugs? If so, which and when? ____________________________________

OVER
REVIEW OF SYMPTOMS (PLEASE CIRCLE ALL OF THE FOLLOWING THAT APPLY):

**Neurological**

Loss of Smell  
Double Vision  
Difficulty swallowing  
Vision loss in one eye or the other  
Hearing loss  
Trouble with Balance/Coordination  
Ringing in the ears  
Back pain  
Weakness

**General**

Weight Loss in the past year  
Weight gain in the past year  
Chest Pain  
Breast discharge  
Irregular heart beat  
Heart murmur  
Nausea/Vomiting  
Easy bruising  
Fever/Chills  
Frequent nose bleeds  
Hoarse voice  
Frequent headaches  
Shortness of Breath  
Kidney disease  
Liver disease  
Previous anesthesia issues  
Excessive bleeding during/after prior surgical procedure

**For Women:**

Last menstrual period? ____________________________  
Breast swelling or drainage? ____________________________

**For Men:**

Prostate problems: ____________________________  
Genitourinary problems: ____________________________