MINIMALLY INVASIVE BRAIN AND SPINE

New Patient Intake Form **Date**: _____

I. Demographic Information

Name:_____ Date of Birth_____ Age_____

Home Address:_____

Home Phone:_____ Cell Phone_____

Emergency contact:_____ Phone number:_____

II. Care Information-please list a complete name and address of physicians (VERY IMPORTANT)

Primary Care Physician: _____

Address: _____

Office Phone: _____ Office Fax: _____

Referring Physician: _____Specialty: _____

Address: _____ City: _____State: _____Zip: _____

Office Phone: _____Office Fax: _____

Pharmacy: _____ Address: _____

Phone: _____ Fax: _____

III. Reason for visit-Chief Complaint
Describe the major problem that brings you to see a Neurosurgeon:

_____

Is this visit related to workers compensation? Yes No
Is this visit related a result of an accident, when did accident occur? _____
Is this visit related to any legal actions? Yes No

Patient Name_____

IV**. Surgical History**: Please list all operations you have had: Date:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

V. **Medical History:** Please list all active medical conditions: Duration:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list all MEDICATIONS you take routinely, prescribed or over the counter, include dosages:

Medications:	**Dose:**	**Frequency:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name_____

ARE YOU ALLERGIC TO ANY MEDICIATIONS? _____

_____

ALERRGIC TO LATEX, X-RAY DYE, OR IDODINE? (circle one)

Are you taking ANY "blood thinning" medications ( ) YES- indicate below ( ) No

Aspirin or aspirin-containing medication ( ) Anti Inflammatory medication ( ) Plavix ( )

Coumadin ( ) Fish oil ( ) Other: _____

VI. Social History:

Occupation: _____ Marital Status: _____ Number of children: _____

Do you smoke cigarettes? ( ) Yes ( ) No

Have you ever smoked cigarettes? ( ) Yes ( ) No

If so, how many packs a day? _____ What age did you start? _____

Do you drink alcohol? ( ) Yes ( ) No

If so, how many drinks per day: _____

Do you use recreation drugs? ( ) Yes ( ) No

Do you exercise regularly? ( ) Yes ( ) No

VII. Family History Do you have a family member affected with:

Condition	Yes	No	Condition	Yes	No
Cancer	( )	( )	Bleeding/Clotting	( )	( )
Heart Disease	( )	( )	High Cholesterol	( )	( )
Hypertension	**( )**	**( )**	Diabetes	**( )**	**( )**

Other Conditions_____

_____

Patient Name_____

Viii. Review of symptoms Do you currently, or have you had a problem with:

Circle One

Constitutional:

Change in appetite	Yes No	Chills/rigors	Yes No
Decreased Activity	Yes No	Fatigue	Yes No
Fever	Yes No	Insomnia	Yes No
Irritability	Yes No	Weight gain	Yes No
Weight loss	Yes No		

Eyes:		**Ears:**	
Burning	Yes No	Discharge	Yes No
Double Vision	Yes No	Hearing loss	Yes No
Visual loss	Yes No	Infections	Yes No
Discharge	Yes No	Pain	Yes No
Intolerance to Light	Yes No	Ear Ringing	Yes No
Pain	Yes No	Vertigo (dizziness/Spinning)	Yes No

Nose & Sinus		**Throat & Mouth**	
Inability to smell	Yes No	Change in Taste	Yes No
Nasal Drainage	Yes No	Voice Change	Yes No
Nose bleeds	Yes No	Hoarseness	Yes No
Nasal Congestion	Yes No	Pain when Swallowing	Yes No
Sinusitis	Yes No	Snoring	Yes No

Respiratory

Accelerated respirations	Yes No		
Cough	Yes No	Bloody Sputum	Yes No
Shortness of breath	Yes No	Pain respirations	Yes No
Frequent upper respiratory infections	Yes No	Snoring	Yes No

Cardiovascular

Chest Pain	Yes No	Edema	Yes No
Shortness of breath	Yes No	Irregular heart/beat/palpations	Yes No

Gastrointestinal

Abdominal pain	Yes No	Vomiting	Yes No
Change in bowl habits	Yes No	Jaundice	Yes No
Blood in stool	Yes No	Heartburn	Yes No
Nausea	Yes No		

Patient Name_____

Genitourinary

Back Pain	Yes No	Change in urine color	Yes No
Frequent urination	Yes No	Urinary incontinence	Yes No
Blood in urine	Yes No	excessive amounts of urine	Yes No
Painful urination	Yes No	Urgency	Yes No

Metabolic/Endocrine

Abnormal sleep pattern	Yes No	Increased activity	Yes No
Chronically overweight	Yes No	Weight gain	Yes No
Chronically underweight	Yes No	Weight loss	Yes No
Excessive sweating	Yes No	Cold Intolerance	Yes No

Neuro/Psychiatric

Dizziness	Yes No	Headache	Yes No
Gait disturbance	Yes No	Incontinence	Yes No
Memory Impairment	Yes No	Seizures	Yes No
Visual changes	Yes No	Speech changes	Yes No

Dermatologic

Hair loss	Yes No	Rash	Yes No
Change in mole	Yes No	Skin lesion	Yes No
Skin infections	Yes No	Excessive sweating	Yes No

Musculoskeletal

Back pain	Yes No	Bone/joint symptoms	Yes No
Muscle weakness	Yes No	Neck stiffness	Yes No

Hematologic

Easy bleeding	Yes No	Easy bruising	Yes No
Low blood cell count	Yes No	Abnormal lymph node size	Yes No

Immunological

Environmental allergies	Yes No	Food allergies	Yes No
Asthma	Yes No	Hay fever	Yes No