Patient Name: _____ DOB:

TRI-STATE NEUROSURGERY PATIENT INTAKE FORM

Name: _____

DOB: _____/_____/_____ Age: _____

Gender: Male or Female **(circle one)** Pain Level: 0 1 2 3 4 5 6 7 8 9 10 **(circle one)**

Height: _____feet _____inches Weight: _____lbs.

What is the main reason for your visit? _____

_____

Are there any recent events or problems that have caused you concern? Specify:

_____

_____

CURRENT MEDICATIONS

Are you taking any medications? Yes No **(circle one)**

If yes, then please list all current medications including over the counter medications, herbal remedies, etc:

NAME OF MEDICATION DOSE HOW OFTEN? REASON FOR TAKING?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10.
11.

Patient Name: _____ DOB:

ALLERGIES

Are you allergic to any drugs or radiology dyes? Yes No **(circle one)**

If yes, please list them here:

Allergic To: Reaction (what happens?):

_____

_____

MEDICAL HISTORY (Circle Yes or No for each problem)

YES	NO	Allergies
YES	NO	Anemia
YES	NO	Anxiety
YES	NO	Arthritis
YES	NO	Asthma
YES	NO	Blood transfusion
YES	NO	Cancer
YES	NO	Cataracts
YES	NO	Congestive Heart Failure (CHF)
YES	NO	Clotting disorder (bleeding problems)
YES	NO	COPD (lung problem)
YES	NO	Depression
YES	NO	Diabetes Mellitus
YES	NO	Emphysema (lung problem)
YES	NO	GERD
YES	NO	Glaucoma
YES	NO	Heart murmur
YES	NO	HIV/AIDs
YES	NO	High blood pressure
YES	NO	Kidney disease
YES	NO	Meningitis
YES	NO	Post-Menopause
YES	NO	Heart attack
YES	NO	Nerve/muscle problems
YES	NO	Osteoporosis
YES	NO	Seizures

Patient Name: _____ DOB:

YES	NO	Sickle cell anemia
YES	NO	Stroke
YES	NO	Substance abuse (Drug/alcohol problems)
YES	NO	Thyroid disease
YES	NO	Tuberculosis
YES	NO	Ulcers
YES	NO	Other (please specify):

HOSPITALIZATIONS

Have you been admitted to the hospital before? Yes No **(circle one)**

If yes, please give details below:

REASON MONTH/YEAR

_____

_____

_____

_____

_____

_____

SURGERIES (Circle Yes or No for each procedure)

YES	NO	Appendectomy
YES	NO	Brain surgery
YES	NO	Breast surgery
YES	NO	CABG (open heart surgery)
YES	NO	Cholecystectomy
YES	NO	Colon surgery
YES	NO	Cosmetic surgery
YES	NO	C-section
YES	NO	Eye surgery
YES	NO	Fracture (bone) surgery

Patient Name: _____ DOB:

YES	NO	Hernia repair
YES	NO	Hysterectomy
YES	NO	Joint Replacement (knee, hip, etc)
YES	NO	Small intestine surgery
YES	NO	Spine surgery (neck or back)
YES	NO	Tubal ligation
YES	NO	Vasectomy
YES	NO	Valve replacement
YES	NO	Other (please specify):

FAMILY HISTORY (Place a check mark in any box/disease that applies to one of your family member)

Relationship:	Mother	Father	Sister	Brother	Daughter	Son
Alcohol abuse						
Arthritis						
Asthma						
Birth defects						
Cancer						
COPD						
Depression						
Diabetes						
Drug abuse						
Early death						
Hearing loss						
Heart disease						
High cholesterol						
High blood pressure						
Kidney disease						
Learning disability						
Mental illness						
Mental retardation						
Miscarriage						
Stroke						
Visual loss						

Patient Name: _____ DOB:

Tremor						
Parkinson's disease						
Dystonia						
Brain disease						

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed **(circle one)**

Do you drink alcohol? Yes No **(circle one)**

If no, how long has it been since you had alcohol? _____

If yes, how much and what do you drink each day? _____

Do you smoke cigarettes? Yes No **(circle one)**

If yes, average number of packs per day? _____How many years? _____

Do you use recreational drugs? Yes No **(circle one)**

If yes, please provide details? _____

How many grades did you complete in school? _____

Are you currently employed? Yes No **(circle one)**

What is or was your primary job? _____

If you are retired, when did you retire or leave your work? _____

Did you retire due to your movement disorder? Yes No **(circle one)**

FUNCTIONAL STATUS

Have you experienced any change in your ability to do your usual activities at home, at work, exercising, or doing your hobbies? Yes No **(circle one)**

If yes, please explain: _____

_____

OTHER DOCTORS

If you want a copy of this visit report to be sent to your other doctors, then please list their information below:

Patient Name: _____ DOB:

Referring Doctor *(What type of doctor):*

Dr. _____

Address: _____

City, State, Zip: _____

Phone number: _____

Primary Care Doctor *(What type of doctor):*

Dr. _____

Address: _____

City, State, Zip: _____

Phone number: _____

Other Doctor:

Dr. _____

Address: _____

City, State, Zip: _____

Phone number: _____

What type of doctor? _____

Other Doctor:

Dr. _____

Address: _____

City, State, Zip: _____

Phone number: _____

What type of doctor? _____

Name: _____ DOB:

Review of Symptoms. Circle those that apply:			
ACTIVITY CHANGE	***EYES***	***GU***	NUMBNESS
APPETITE CHANGE	EYE DISCHARGE	DIFFICULTY URINATING	SEIZURES
CHILLS	EYE PAIN	DYSPAREUNIA (PAINFUL SEXUAL INTERCOURSE)	SPEECH DIFFICULTY
DIAPHORESIS (SWEATING)	EYE REDNESS	DYSURIA (PAINFUL URINATION)	SYNCOPE (FAINTING)
FATIGUE	PHOTOPHOBIA (SENSITIVITY TO LIGHT)	ENURESIS (INVOLUNTARY URINATION)	TREMORS
FEVER	VISUAL DISTURBANCE	FLANK PAIN (UPPER ABDOMEN OR BACK)	WEAKNESS
WEIGHT CHANGE	***RESPIRATORY***	FREQUENCY	***HEMATOLOGIC***
HEAD AND NECK	APNEA (SUSPENSION OF BREATHING)	URGENCY	ADENOPATHY (ENLARGED LYMPH NODE
FACIAL SWELLING	CHEST TIGHTNESS	HEMATURIA (BLOOD IN URINE)	BRUISES/BLEEDS EASILY
NECK PAIN	CHOKING	DECREASED URINE	***PSYCHIATRIC***
NECK STIFFNESS	COUGH	***MS***	AGITIATION
EAR DISCHARGE	SHORTNESS OF BREATH	ARTHRALGIA (JOINT PAIN)	BEHAVIOR PROBLEM
HEARING LOSS	WHEEZING	BACK PAIN	CONFUSION
EAR PAIN	***CARDIOVASCULAR***	GAIT PROBLEM (UNSTEADY WALK)	DECREASE CONCENTRATION
TINNITUS (RINGING IN EARS)	CHEST PAIN	JOINT SWELLING	DYSPHORIC MOOD (UNWELL/UNHAPPY)
NOSEBLEEDS	LEG SWELLING	MYALGIAS (MUSCLE ACHES)	HALLUCINATIONS
CONGESTION	PALPITATIONS (ABNORMAL HEART BEAT)	***SKIN***	HYPERACTIVE
RHINORRHEA (RUNNY-NOSE)	***GI***	COLOR CHANGE	NERVOUS/ANXIOUS
POSTNASAL DRIP	ABDOMINAL PAIN	PALLOR	SELF-INJURY
SNEEZING	ANAL BLEEDING	RASH	SLEEP DISTURBANCE

Name: _____ DOB: