

**GREAT LAKES NEUROSURGERY
MEDICAL HEALTH HISTORY FORM**

PATIENT'S NAME _____ **AGE** _____ **DOB** _____

___ Male ___ Female Estimated Height _____ Weight _____

___ Left handed ___ Right handed

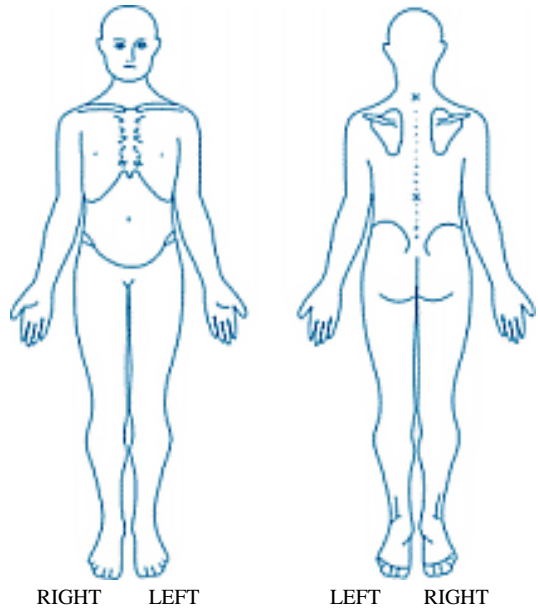
___ Married ___ Single ___ Divorced ___ Widowed ___ Separated

Referred by _____ (M.D., D.O., D.C., P.A.)

Family Physician _____ (M.D., D.O., D.C., P.A.)

WHAT IS THE REASON FOR TODAY'S APPOINTMENT

If you have pain, numbness or tingling,
Please complete the following:



Please indicate with an "X or O" on the
Accompanying diagrams the location of your symptoms.

Have you experienced any of these associated problems?

- | | | |
|---------------------------------------|------------------------------------|---|
| ___ Headaches | ___ Uncontrollable pain | ___ Inability to control bowel or
bowel or bladder |
| ___ Fever or chills | ___ Erectile dysfunction | ___ Unexplained weight loss |
| ___ Clumsiness in hands | ___ Loss of power in legs | ___ Frequent stumbling or falling |
| ___ Weakness | ___ Pain with coughing or sneezing | ___ Difficulty standing up straight |
| ___ Numbness or tingling | ___ Confusion | |
| ___ I HAVE NONE OF THE ABOVE PROBLEMS | | |
| ___ Other _____ | | |

Indicate current level of pain on the following scale:

No Pain Intolerable
0 1 2 3 4 5 6 7 8 9 10

What makes your condition worse? _____

What helps your condition? _____

Other body parts affected: _____

Symptoms affected by: _____

Loss of bowel or bladder control? _____

DIAGNOSTIC STUDIES: What tests have been completed? (list dates)

MRI _____ CT SCAN _____ SPINE X-RAYS _____ MYELOGRAM _____ EMG _____

TREATMENT MODALITIES (What procedures have you had for the treatment of your current Problem? Please circle all that apply).

Surgery Nerve blocks Steroid Injections Physical Therapy
Tens Unit Psychological Counseling Chiropractic NSAIDS

MEDICAL HISTORY

ALLERGIES

Medications _____

Other _____

CURRENT PRESCRIPTION MEDICATIONS

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

NONPRESCRIPTION MEDICATION

(Over the counter drugs/vitamins/herbal preparations/nonsteroidal anti inflammatory)

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

PAST MEDICAL HISTORY

(Please circle all conditions that you have or have had)

Heart Disease	Bleeding Difficulties	Diabetes Mellitus	Asthma
High Blood Pressure	Hepatitis	Insulin Dependent	TB
Stroke	HIV	Oral Medication	Emphysema
Cancer (type/treatment, and date) _____		Diet Controlled	Arthritis
_____		Other (Specify) _____	
_____		_____	
_____		_____	

PAST SURGICAL HISTORY

Type of surgery	Year	Type of surgery	Year
1. _____		4. _____	
2. _____		5. _____	
3. _____		6. _____	

SOCIAL HISTORY

Do you smoke? **YES** **NO** How many packs/day? _____ For how long? _____

Do you consume alcohol? **YES** **NO** How much? _____ how often? _____

Have you ever had a problem with alcohol in the past? **YES** **NO** When? _____

Have you ever used illegal drugs? **YES** **NO** When? _____

Have you ever had an addiction problem with narcotic pain medications?
YES **NO** When? _____

FAMILY HISTORY (Check any medical problems that exist in your family)

_____ High blood pressure	_____ Diabetes	_____ Heart disease
_____ Stroke	_____ Bleeding disorder	_____ Reaction to anesthesia
_____ Emphysema/COPD		
_____ Cancer (type) _____		
_____ Other medical illness (describe) _____		

OCCUPATIONAL HISTORY

Presently employed Presently Unemployed Retired

Present Employer: _____

Dates of time lost from work _____

Were you injured at work? _____

Description of job (amount of time sitting and lifting)

Are you currently on disability? Yes No

If yes, what type Workman's comp Social Security
 Other

Were you involved in a motor vehicle accident? Yes No

If yes, date and type of injury _____

Are you currently involved in a lawsuit? Yes No

REVIEW OF SYSTEMS

(Please circle any of the following you currently experience)

GENERAL

- Weight loss
- Weight gain
- Fever
- Fatigue

EYES

- Pain
- Discharge
- Light Sensitivity
- Blurred Vision

EARS, NOSE, THROAT

- Sore Throat
- Hoarseness
- Ear Ringing
- Nose Bleeds

RESPIRATORY

- Wheezing
- Cough
- Shortness of breath

CARDIOVASCULAR

- Chest Pain
- Fainting
- Feet Swelling
- Palpitations
- Pacemaker

GASTROINTESTINAL

- Abdominal Pain
- Nausea
- Vomiting
- Diarrhea
- Blood in Stool

GENITOURINARY

- Frequency
- Hesitancy
- Flank Pain
- Painful Urination
- Blood in Urine

NEUROLOGICAL

- Headache
- Confusion
- Numbness
- Slurred Speech
- Seizure

MUSCULOSKELETAL

- Joint Swelling
- Joint Redness
- Joint Pain
- Gait Problems

SKIN/BREAST

- Rash
- Itching
- Sores
- Abscess
- Discharge

ENDOCRINE

- Excess Sweat
- Excess Thirst
- Excess Hot
- Excess Cold

HEMATOLOGIC/LYMPHATIC

- Bleeding Tendencies
- Lymph Node Swelling
- Easy Bruising

PSYCHOLOGIC

- Anxiety
- Depression
- Severe Stress
- Panic

Explanation or other _____

Signature _____ Date _____