

Adult Neurological Surgery

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Diplomate
American Board of
Neurological Surgery

Patients Name: _____ **Date of Birth** _____

Name of Family and/or referring physician: _____

Present Complaint: _____

MEDICAL HISTORY: Do you have or have you ever had the following? If a member of your family has a history of any of these diseases, please mark which member.

	You	Family Member	MD's Comments
Diabetes			
Asthma			
Kedney Trouble			
Seizures			
Arthritis			
Tuberculosis			
Hypertension			
Heart Trouble			
Ulcers			
Bleeding Problems			

Please list any other health problems: _____

Do you have allergies to medication: _____

Do you smoke cigarettes? _____ **Do you use alcohol?** _____

Are you currently using medications? _____ **If yes, please list:** _____

Are you right or left handed? _____

SURGICAL HISTORY: Please list any and all operations you have had in the past

Type of Surgery	Surgeon	Date	Hospital

Patient Signature _____ **Date** _____

Physician Signature _____ **Date** _____