

**COASTAL NEW HAMPSHIRE NEUROSURGEONS**

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**Adult Neurological Surgery**

**Diplomate, American Board of Neurological Surgery**

Ms.  
Mrs.  
NAME: Mr. \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
Dr. \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
Rev. \_\_\_\_\_ LENGTH OF EMPLOYMENT \_\_\_\_ YEAR(S)  
How would you like to be addressed? \_\_\_\_\_  
AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
HANDEDNESS: Right \_\_\_\_\_ or Left \_\_\_\_\_

REASON FOR YOUR NEUROSURGICAL CONSULTATION (MAIN COMPLAINT) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE OF ONSET OF SYMPTOMS \_\_\_\_\_

WAS ONSET OF SYMPTOMS WORK RELATED? YES/NO OR ACCIDENT RELATED? YES/NO

If YES, describe circumstances \_\_\_\_\_

If work-related injury, has it been accepted as a workmen's compensation case? YES/NO

If an accident-related injury, is any insurance dispute or lawsuit pending? YES/NO

Please list your symptoms with precise location (start with the most bothersome/worrisome symptom and end with the last):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Do you relate your symptoms to certain activities: YES/NO

If YES, list activities that increase/decrease symptoms:

INCREASE:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

DECREASE:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

PHYSICIAN INITIALS \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Are your symptoms: WORSENING \_\_\_\_\_ IMPROVING \_\_\_\_\_ STAYING SAME \_\_\_\_\_

On a scale of 0-10. Please rate the intensity of any painful symptoms:

SCALE: 0= no pain, feeling perfect

10= most severe pain imaginable under any circumstances in a human being

WORST LEVEL of pain at any time \_\_\_\_\_

AVERAGE RECENT DAY-TO-DAY LEVEL of pain \_\_\_\_\_

LEAST LEVEL of pain at any time \_\_\_\_\_

Are your symptoms: CONSTANT \_\_\_\_\_ INTERMITTENT \_\_\_\_\_ UP AND DOWN \_\_\_\_\_

UNPREDICTABLE \_\_\_\_\_ NOT PRESENT NOW \_\_\_\_\_

Have your symptoms: INTERFERED WITH WORK \_\_\_\_\_ SOCIAL LIFE \_\_\_\_\_

RECREATION \_\_\_\_\_ ATHLETICS \_\_\_\_\_

Have you been DISABLED FOR WORK? Temporarily YES/NO DATE \_\_\_\_\_

Permanently YES/NO DATE \_\_\_\_\_

What physician authorized the disability? \_\_\_\_\_

List any physicians/osteopath/chiropractor whom you have consulted or who has treated you for these symptoms:

1. \_\_\_\_\_ Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

2. \_\_\_\_\_ Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

3. \_\_\_\_\_ Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

4. \_\_\_\_\_ Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

What specific objectives or wishes do you have regarding today's consultation?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY:**

NAME OF PERSONAL PHYSICIAN(S)

SPECIALTY

\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_

NAME OF PHYSICIAN WHO REFERRED YOU TODAY:

\_\_\_\_\_/\_\_\_\_\_

ARE YOU CURRENTLY BEING TREATED FOR ANY ACTIVE MEDICAL OR PSYCHIATRIC CONDITION? If so, specify:

CONDITION	PHYSICIAN	DATE OF ONSET
1. _____	_____/_____	____/____/____
2. _____	_____/_____	____/____/____
3. _____	_____/_____	____/____/____
4. _____	_____/_____	____/____/____
5. _____	_____/_____	____/____/____

PHYSICIAN INITIALS \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

HAVE YOU HAD ANY SERIOUS MEDICAL OR PSYCHIATRIC ILLNESS OR HOSPITALIZATION IN THE PAST YEAR?

	CONDITION	PHYSICIAN	DATE OF ONSET
1.	_____ / _____	_____ / _____	_____ / _____
2.	_____ / _____	_____ / _____	_____ / _____
3.	_____ / _____	_____ / _____	_____ / _____
4.	_____ / _____	_____ / _____	_____ / _____
5.	_____ / _____	_____ / _____	_____ / _____
6.	_____ / _____	_____ / _____	_____ / _____

LIST ANY OPERATIONS/SURGERY YOU HAVE HAD.

	CONDITION	PHYSICIAN	DATE OF ONSET
1.	_____ / _____	_____ / _____	_____ / _____
2.	_____ / _____	_____ / _____	_____ / _____
3.	_____ / _____	_____ / _____	_____ / _____
4.	_____ / _____	_____ / _____	_____ / _____
5.	_____ / _____	_____ / _____	_____ / _____
6.	_____ / _____	_____ / _____	_____ / _____

ARE YOU ALLERGIC OR SENSITIVE TO ANY FOOD OR MEDICATIONS? YES/NO  
IF YES, specify:

	NAME OF SUBSTANCE	TYPE OF ADVERSE REACTION
1.	_____ / _____	_____ / _____
2.	_____ / _____	_____ / _____
3.	_____ / _____	_____ / _____
4.	_____ / _____	_____ / _____
5.	_____ / _____	_____ / _____
6.	_____ / _____	_____ / _____

ARE YOU ALLERGIC OR SENSITIVE TO **LATEX**? YES/ NO

LIST ALL MEDICATIONS (PRESCRIPTIONS AND/OR OVER THE COUNTER) BEING TAKEN DAILY OR AS NEEDED:

	MEDICATION NAME	DOSE	HOW OFTEN	PRESCRIBING PHYSICIAN
1.	_____ / _____	_____ / _____	_____ / _____	_____ / _____
2.	_____ / _____	_____ / _____	_____ / _____	_____ / _____
3.	_____ / _____	_____ / _____	_____ / _____	_____ / _____
4.	_____ / _____	_____ / _____	_____ / _____	_____ / _____
5.	_____ / _____	_____ / _____	_____ / _____	_____ / _____
6.	_____ / _____	_____ / _____	_____ / _____	_____ / _____

PHYSICIAN INITIALS \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

DO YOU SMOKE/CHEW TOBACCO PRODUCTS? YES/NO IF YES, state:  
WHAT TYPE HOW MUCH PER DAY HOW MANY YEAR  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

DO YOU DRINK ALCOHOLIC PRODUCTS? YES/NO IF YES, state  
WHAT TYPE HOW MUCH PER DAY HOW MANY YEAR  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

HAVE YOU EVER USED "RECREATIONAL OR ILLICIT" DRUGS OR SUBSTANCES OF ANY TYPE? YES/NO

HAVE YOU EVER HAD A PROBLEM WITH ALCOHOL OR OTHER SUBSTANCE ABUSE? YES/NO WHEN \_\_\_\_\_

ARE YOU (circle one)  
SINGLE MARRIED LIVING W/SIGNIFICANT OTHER SEPARATED DIVORCED REMARRIED

DO YOU HAVE CHILDREN? YES/NO HOW MANY \_\_\_\_\_

WHAT EDUCATION LEVEL DO YOU HAVE \_\_\_\_\_

DO YOU HAVE ANY CONCERN OR REASON TO BELIEVE YOU ARE "AT RISK" OR ACTUALLY HAVE **AIDS**- Acquired Immune Deficiency Sndrome OR COMPLEX? YES/ NO  
(NG: By law, you may elect to NOT answer this question)  
Explain \_\_\_\_\_  
\_\_\_\_\_

HAVE YOU HAD HEPATITIS? YES/ NO WHEN? \_\_\_\_\_

HAVE YOU HAD ANY BLOOD OR BLOOD PRODUCT TRANSFUSIONS: YES/ NO  
When? \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Are there any medical conditions in several members or generations of your family?

\_\_\_\_\_  
\_\_\_\_\_

	AGE	LIVING/DECEASED	MAJOR MEDICAL PROBLEMS OR CAUSE OF DEATH
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

PHYSICIAN INITIALS \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**REVIEW OF SYMPTOMS (RELATIVE TO YOUR CURRENT HEALTH)**

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ ANY CURRENT WEIGHT LOSS? YES/NO

Putting aside the principle symptoms or reasons you are being seen today, do you have any other symptoms affecting other areas of your body?

**HEAD**

**YES NO**

Repeated headaches/ migraine \_\_\_\_\_

Seizures/convulsion, epilepsy \_\_\_\_\_

Dizziness/loss of balance \_\_\_\_\_

Blackouts/loss of consciousness \_\_\_\_\_

Hiccups or nausea unrelated to eating \_\_\_\_\_

**EYES**

Change in vision quality or loss of vision \_\_\_\_\_

Blurred or double vision \_\_\_\_\_

Difficulty reading or watching TV \_\_\_\_\_

**EARS**

Loss of hearing \_\_\_\_\_

Ringing or other sounds in ears \_\_\_\_\_

Difficulty with balance \_\_\_\_\_

**MOUTH**

Diseased/infected teeth \_\_\_\_\_

Non-healing sores of mouth , gums, tongue or throat \_\_\_\_\_

Painful or restricted neck movement \_\_\_\_\_

Masses/lumps/enlarged lymph glands \_\_\_\_\_

**CHEST**

Difficulty breathing during exercise \_\_\_\_\_

Shortness of breath at rest \_\_\_\_\_

Pain in ribcage \_\_\_\_\_

Chronic cough \_\_\_\_\_

Blood in sputum \_\_\_\_\_

**HEART**

Sharp or crushing left sided chest pain (angina) \_\_\_\_\_

Pain or numbness radiating to the left jaw/shoulder/arm \_\_\_\_\_

Palpitations or irregular heartbeat \_\_\_\_\_

Swelling in legs/ankle/feet \_\_\_\_\_

Blackouts \_\_\_\_\_

**GASTROINTESTINAL**

Nausea or vomiting \_\_\_\_\_

Abdominal pain or cramping \_\_\_\_\_

Change in bowel habits \_\_\_\_\_

Change in appearance of stool \_\_\_\_\_

Vomiting blood or passing blood in stool \_\_\_\_\_

Jaundice or yellow discoloration of skin \_\_\_\_\_

Food intolerance (specify) \_\_\_\_\_

PHYSICIAN INITIALS \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**GENITOURINARY**

YES NO

Painful or difficult urination \_\_\_\_\_  
Urgent urination \_\_\_\_\_  
Blood/pus/grit in urine \_\_\_\_\_  
Discolored urine \_\_\_\_\_  
Repeated urination at night \_\_\_\_\_  
Urethral or vaginal discharge \_\_\_\_\_  
Incontinence-loss of bladder control \_\_\_\_\_  
Consistent thirst and frequent urination \_\_\_\_\_

**EXTREMITIES**

Hot or reddened joints \_\_\_\_\_  
Painful or swollen joints \_\_\_\_\_  
Loss of full range of motion in joints \_\_\_\_\_  
Pain over shaft of long bone \_\_\_\_\_  
Discoloration or coldness of extremities \_\_\_\_\_  
Change in appearance or shape if muscle groups \_\_\_\_\_  
Difficulty walking \_\_\_\_\_

**NEUROLOGICAL**

Loss of taste \_\_\_\_\_  
Loss of sense of smell \_\_\_\_\_  
Difficulty with speech \_\_\_\_\_  
Loss of memory (distant/recent/immediate) \_\_\_\_\_  
Irrational or changed behavior \_\_\_\_\_  
Alteration in mood \_\_\_\_\_  
Change in personality \_\_\_\_\_  
Weakness or incoordination on any extremity \_\_\_\_\_  
Numbness or altered skin sensation anywhere \_\_\_\_\_  
Loss of balance \_\_\_\_\_  
Difficulty walking or standing \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_