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**COASTAL NEW HAMPSHIRE NEUROSURGEONS**  
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Adult Neurological Surgery

Diplomate, American Board of Neurological Surgery

**PATIENT INFORMATION**

**NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_

**REFERRED BY** \_\_\_\_\_

Address \_\_\_\_\_

**FAMILY PHYSICIAN** \_\_\_\_\_

Address \_\_\_\_\_

**CHIEF COMPLAINT** \_\_\_\_\_

**ONSET OF SYMPTOMS** \_\_\_\_\_ **DATE OF INJURY** \_\_\_\_\_

**RIGHT HAND** \_\_\_\_\_ **LEFT HAND** \_\_\_\_\_ **AMBIDEXTROUS** \_\_\_\_\_

**ARE YOU ALLERGIC TO MEDICATIONS?** Yes \_\_\_ No \_\_\_ Latex/Adhesive? Y N

If yes, list medications you cannot take:

_____	REACTION _____
_____	REACTION _____
_____	REACTION _____

**CURRENT MEDICATIONS:**

_____	DOSAGE _____
_____	DOSAGE _____
_____	DOSAGE _____
_____	DOSAGE _____
_____	DOSAGE _____
_____	DOSAGE _____
_____	DOSAGE _____

**PATIENT'S PAST MEDICAL HISTORY** (If yes, give date):

CHILDHOOD DISEASES \_\_\_\_\_

HYPERTENSION \_\_\_\_\_ THYROID DYSFUNCTION \_\_\_\_\_

DIABETES \_\_\_\_\_ SEIZURES \_\_\_\_\_

CHOLESTEROL \_\_\_\_\_ MIGRAINE \_\_\_\_\_

HEART ATTACK \_\_\_\_\_ OTHER \_\_\_\_\_

ANGINA \_\_\_\_\_

**PROVIDER INITIALS** \_\_\_\_\_

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

**DESCRIPTION OF INJURY OR COMPLAINT**

**DESCRIBING SYMPTOMS** \_\_\_\_\_

**ONSET OF AND PRESENT** \_\_\_\_\_

**WHEN ARE THE SYMPTOMS MORE SEVERE?** (Describe in full)

\_\_\_\_\_  
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**LIST SURGERY THAT YOU HAVE HAD AND THE DATE OF SURGERY:**

1. SURGERY \_\_\_\_\_ DATE \_\_\_\_\_

HOSPITAL \_\_\_\_\_

WAS IT MALIGNANT OR BENIGN? YES \_\_\_ NO \_\_\_

2. SURGERY \_\_\_\_\_ DATE \_\_\_\_\_

HOSPITAL \_\_\_\_\_

WAS IT MALIGNANT OR BENIGN? YES \_\_\_ NO \_\_\_

3. SURGERY \_\_\_\_\_ DATE \_\_\_\_\_

HOSPITAL \_\_\_\_\_

WAS IT MALIGNANT OR BENIGN? YES \_\_\_ NO \_\_\_

4. SURGERY \_\_\_\_\_ DATE \_\_\_\_\_

HOSPITAL \_\_\_\_\_

WAS IT MALIGNANT OR BENIGN? YES \_\_\_ NO \_\_\_

5. SURGERY \_\_\_\_\_ DATE \_\_\_\_\_

HOSPITAL \_\_\_\_\_

WAS IT MALIGNANT OR BENIGN? YES \_\_\_ NO \_\_\_

6. SURGERY \_\_\_\_\_ DATE \_\_\_\_\_

HOSPITAL \_\_\_\_\_

WAS IT MALIGNANT OR BENIGN? YES \_\_\_ NO \_\_\_

**PROVIDER INITIALS** \_\_\_\_\_

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

**PROVIDER INITIALS** \_\_\_\_\_

**GYN: # OF PREGNANCIES** \_\_\_\_\_ **MISCARRIAGES** \_\_\_\_\_ **TERMINATIONS** \_\_\_\_\_

**SOCIAL HISTORY:** Smoke \_\_\_\_\_ Packs per day \_\_\_\_\_  
Alcohol \_\_\_\_\_ Frequency \_\_\_\_\_  
Coffee \_\_\_\_\_ Cups per day \_\_\_\_\_ Tea \_\_\_\_\_ Cups per day \_\_\_\_\_

**EDUCATION** \_\_\_\_\_

**OCCUPATION**(Present or past if retired) \_\_\_\_\_

**PRESENT EMPLOYMENT** \_\_\_\_\_

Address \_\_\_\_\_

**MARITAL STATUS** \_\_\_\_\_ **CHILDREN** \_\_\_\_\_ **LIVING** \_\_\_\_\_ **DECEASED** \_\_\_\_\_

**MILITARY SERVICES** \_\_\_\_\_ **ACTIVE** \_\_\_\_\_ **RESERVES** \_\_\_\_\_

**PSYCHIATRIC** \_\_\_\_\_ **DOCTOR** \_\_\_\_\_

**DATE OF CARE** \_\_\_\_\_

**FAMILY HISTORY:**

**MOTHERS AGE** \_\_\_\_\_ **LIVING OR DECEASED** \_\_\_\_\_ **IF DECEASED, CAUSE** \_\_\_\_\_  
Medical problems if living \_\_\_\_\_

**FATHERS AGE** \_\_\_\_\_ **LIVING OR DECEASED** \_\_\_\_\_ **IF DECEASED, CAUSE** \_\_\_\_\_  
Medical problems if living \_\_\_\_\_

**SISTERS** \_\_\_\_\_ **LIVING** \_\_\_\_\_ **DECEASED** \_\_\_\_\_ **CAUSE** \_\_\_\_\_ **AGE AT DEATH** \_\_\_\_\_  
Medical problems if living \_\_\_\_\_

**BROTHERS** \_\_\_\_\_ **LIVING** \_\_\_\_\_ **DECEASED** \_\_\_\_\_ **CAUSE** \_\_\_\_\_ **AGE AT DEATH** \_\_\_\_\_  
Medical problems if living \_\_\_\_\_

**PATIENT: Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**PATIENT'S SIGNATURE** \_\_\_\_\_

**PROVIDER SIGNATURE** \_\_\_\_\_