

Henry F. Pallatroni, MD
COASTAL NEW HAMPSHIRE NEUROSURGEONS
330 Borthwick Avenue Suite 300
Portsmouth, NH 03801

PATIENT INFORMATION

NAME _____ **DATE** _____

Date of Birth _____

ARE YOU ALLERGIC TO MEDICATIONS? Yes ___ No ___

If yes, list medications you cannot take:

_____	REACTION _____
_____	REACTION _____
_____	REACTION _____

CURRENT MEDICATIONS:

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

PAST MEDICAL HISTORY: Place a check next to any medical diseases from which you suffer.

HYPERTENSION _____	THYROID DYSFUNCTION _____
DIABETES _____	SEIZURES _____
CHOLESTEROL _____	MIGRAINE _____
HEART ATTACK _____	ANGINA _____
ASTHMA/COPD _____	DEPRESSION/ANXIETY _____
OTHER PSYCHIATRIC PROBLEMS _____	

List any other medical problems from which you suffer that are not included in the list from above:

LIST SURGERY THAT YOU HAVE HAD AND THE DATE OF SURGERY:

1. SURGERY _____ DATE _____
HOSPITAL _____

2. SURGERY _____ DATE _____
HOSPITAL _____

3. SURGERY _____ DATE _____
HOSPITAL _____

Other Surgeries: _____

PROVIDER INITIALS: _____

Patient Name _____ Date of Birth _____

SOCIAL HISTORY:

Do you do either of the following?

Smoke _____ Packs per day _____

Alcohol _____ Frequency _____

EDUCATION _____

OCCUPATION (Present or past if retired) _____

PRESENT EMPLOYMENT _____

Address _____

MARITAL STATUS _____ CHILDREN _____

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 _____

Review of Systems: Please check off any symptoms that you are currently experiencing pertaining to specific organ systems.

General: Fever ___ Chills ___ Night Sweats ___ Unintended Weight Loss ___ Severe Fatigue ___

Cardiac/Pulmonary: Shortness of Breath ___ Chest Pain ___ Cough ___ Wheezing ___ Blood in Sputum ___

GI: Abdominal Pain ___ Severe Heartburn ___ Diarrhea ___ Constipation ___ Bloody/Dark Stools ___

GU: Difficulty with Urination ___ Incontinence ___ Flank Pain ___ Excessive Urination ___

Endocrine: Unexplained Weight Gain ___ Heat/Cold Intolerance ___ Excessive Thirst ___

Heme: Excessive Bleeding when cut ___ Bloody Gums after brushing ___ Easily Bruised ___

Musculoskeletal: Joint Pain ___ Severe Pain in the spine at night ___ Swelling in ankles ___

PATIENT'S SIGNATURE _____

PROVIDER SIGNATURE _____

