Symeon Missios, MD
COASTAL NEW HAMPSHIRE NEUROSURGEONS

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____