Banner Health®

NEW PATIENT MEDICAL HISTORY
NEUROSURGERY

Patient Name: _____ **Date of Birth:** _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): _____

Primary Care Provider

Name: _____ Phone #: _____

Address: _____ Fax #: _____

Briefly describe the onset of your current pain and events preceding your pain. When and how did it begin?

_____

_____

List all providers who have treated you for this issue: _____

_____

_____

Did you bring X-Rays / EMG / CT / MRI today? ❑ Yes ❑ No

Is this a work related injury? ❑ Yes ❑ No If yes, will you be using workman's comp benefits? ❑ Yes ❑ No

ALLERGIES

List any allergies and intolerances to **medications, food or the environment.** ❑ No Known Allergies

Allergy:	**Reaction:**

MEDICATIONS

❑ Not taking any medications

List any medications, vitamins, supplements, and over the counter medications you are taking, with dose and how often.

Medication Name:	**Dose:**	**How often?**

Are you on aspirin or a blood thinner, such as Warfarin / Xeralto / Plavix / Coumadin / Pradaxa?

❑ Yes ❑ No If yes, medication with dose and frequency: _____

If no, has a physician advised you not to take aspirin? ❑ Yes ❑ No

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9999-0147
(01/2017)

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MEDICAL HISTORY

List all medical conditions you are being treated for (high blood pressure, etc.)

1.	**4.**
2.	**5.**
3.	**6.**

Have you had any recent hospitalizations or ER visits (provide dates and reason below)?

❑ No prior hospitalizations/ER visits

Date	

SURGICAL HISTORY

List all prior surgeries and the date. ❑ No prior surgeries

Date	**Type of Surgery**	**Date**	**Type of Surgery**

FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Brothers				
Sisters				
Daughter				
Son				

SOCIAL HISTORY

Occupation _____ Employer _____

Tobacco/smoking status:	❑ Never				
	❑ Current	Type	Amount	Duration	
	❑ Former	Type	Amount	Duration	
Do you use alcohol?	❑ No	❑ Yes	Type	Amount	Frequency
Do you use recreational drugs?	❑ No	❑ Yes	Type	Amount	Frequency
Do you use Caffeine?	❑ No	❑ Yes	Type	Amount	Frequency

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PAIN ASSESSMENT

When did symptoms begin: _____/_____/ _____

Which is your dominate hand? Right / Left

Location of pain/symptoms:
❑ Brain/head ❑ Face ❑ Neck ❑ Arm(s)
❑ Upper back ❑ Lower back ❑ Hip ❑ Leg(s)

Severity of Pain (0=min, 10=max): _____

Pain Frequency: (mark all that apply)
❑ Rare ❑ Occasional ❑ Constant
❑ Stairs only ❑ Stairs and walking

Status:
❑ Worse ❑ Stable ❑ Improving ❑ Resolved

Radiation of pain:
❑ No ❑ Yes, radiates to: _____

❑ Aching ❑ Burning ❑ Dull
❑ Piercing ❑ Sharp ❑ Throbbing
Other: _____

Injury/Trauma? ❑ No ❑ Yes
If Yes, when/where? (work, school, vacation, automobile, other): _____

Aggravated by: (mark all that apply)
❑ Bending ❑ Lifting ❑ Sitting
❑ Climbing stairs ❑ Movement ❑ Standing
❑ Descending stairs ❑ Pushing ❑ Walking

❑ Nothing
Other:_____

Prior treatment: (mark all that apply)
❑ Brace/splint ❑ Ice ❑ Mobility
❑ Elevation ❑ Injection ❑ Stretching
❑ Exercise ❑ Massage ❑ Physical Therapy
❑ Heat ❑ Rest ❑ Nothing
❑ OTC/prescription meds: _____
Other: _____

Did any of the prior treatments above give relief?
If so, please list: _____

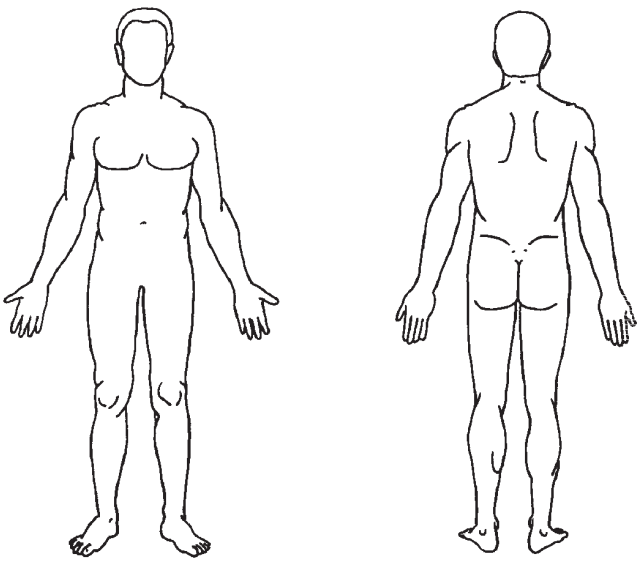
Associated symptoms: (mark all that apply)
❑ Bruising ❑ Limping
❑ Spasms ❑ Pain after inactivity
❑ "Crunching" ❑ Locking
❑ Swelling ❑ Stiffness
❑ Decreased mobility ❑ Wake at night
❑ Tingling in arms ❑ Tingling in legs
❑ Pain at night ❑ Difficulty going to sleep
❑ Joint feels unstable ❑ Numbness
❑ Weakness ❑ Joint tenderness
❑ "Popping"
Other: _____

Functional Abilities: Can you…

Get in/out of car	❑ Yes	❑ No	❑ With difficulty
Kneel	❑ Yes	❑ No	❑ With difficulty
Put on sock/shoes	❑ Yes	❑ No	❑ With difficulty
Go down stairs	❑ Yes	❑ No	❑ With a rail
Go up stairs	❑ Yes	❑ No	❑ With a rail
Sit in chair	❑ 1 hr.	❑ 30 min.	❑ Difficult
Walking distance:	❑ indoors		❑ <5 blocks
	❑ 5-10 blocks		❑ >10 blocks

Do you require a…
❑ Cane ❑ Crutches
❑ Walker ❑ Wheelchair ❑ None

Indicate on the drawing below where you have pain.



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REVIEW OF SYSTEMS

In the last **thirty days,** have you experienced any of the following:

CONSTITUTIONAL			GENITOURINARY			PSYCHIATRIC		
Chills	Yes	No	Blood in urine	Yes	No	Anxiety	Yes	No
Fatigue	Yes	No	Painful urination	Yes	No	Depression	Yes	No
Fever	Yes	No	Polyuria (urinating large volumes)	Yes	No	Insomnia	Yes	No
Malaise	Yes	No	Urinary frequency	Yes	No	**SKIN**		
Night sweats	Yes	No	Urinary incontinence	Yes	No	Contact allergies	Yes	No
Weight gain	Yes	No	Urinary retention	Yes	No	Hives	Yes	No
Weight loss	Yes	No	**REPRODUCTIVE**			Itching	Yes	No
HEENT			Abnormal pap	Yes	No	Mole change	Yes	No
Ear drainage	Yes	No	Breast discharge	Yes	No	Rash	Yes	No
Ear pain	Yes	No	Breast lump	Yes	No	Skin lesion	Yes	No
Eye discharge	Yes	No	Dysmenorrhea	Yes	No	**MUSCULOSKELETAL**		
Eye pain	Yes	No	Hot flashes	Yes	No	Back pain	Yes	No
Hearing loss	Yes	No	Irregular menses	Yes	No	Joint pain	Yes	No
Nasal drainage	Yes	No	Painful intercourse	Yes	No	Joint swelling	Yes	No
Sinus pressure	Yes	No	Vaginal discharge	Yes	No	Muscle weakness	Yes	No
Sore throat	Yes	No	**METABOLIC/ ENDOCRINE**			Neck pain	Yes	No
Vision changes	Yes	No	Brittle hair	Yes	No	**HEMATOLOGIC**		
RESPIRATORY			Brittle nails	Yes	No	Easy bleeding	Yes	No
Chronic cough	Yes	No	Cold intolerance	Yes	No	Easy bruising	Yes	No
Cough	Yes	No	Excessive hunger	Yes	No	Lymphadenopathy	Yes	No
Known TB exposure	Yes	No	Excessive thirst	Yes	No	**IMMUNOLOGIC**		
Shortness of breath	Yes	No	Hair changes	Yes	No	Environmental allergies	Yes	No
Wheezing	Yes	No	Heat intolerance	Yes	No	Food allergies	Yes	No
CARDIOVASCULAR			Hirsutism	Yes	No	Seasonal allergies	Yes	No
Chest pain	Yes	No	**NEUROLOGICAL**					
Claudication (pain in extremities)	Yes	No	Dizziness	Yes	No			
Edema (swelling)	Yes	No	Extremity numbness	Yes	No			
Palpitations	Yes	No	Extremity weakness	Yes	No			
GASTROINTESTINAL			Gait disturbance	Yes	No			
Abdominal pain	Yes	No	Headache	Yes	No			
Blood in stool	Yes	No	Memory loss	Yes	No			
Change in stools	Yes	No	Seizures	Yes	No			
Constipation	Yes	No	Tremors	Yes	No			
Diarrhea	Yes	No						
Heartburn	Yes	No						
Loss of appetite	Yes	No						
Nausea	Yes	No						
Vomiting	Yes	No						

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