Neurological Surgery

Patient History Information

PATIENT NAME____ **DATE**_________________

OCCUPATION: (**If Retired, list previous occupation) ____

PRESENT MEDICATIONS, including dosage: ____

____

____

HERBS / NATURAL PRODUCTS, including dosage: ____

Do you require prophylactic antibiotics? _______Yes _______No Explain:_____________________________

ALLERGIC TO: MEDICATIONS ____

IODINE (Includes sensitivity to shellfish)**:** ___Yes ___No

LATEX (Includes sensitivity to avacado, banana, kiwi)**:** ___Yes* ___No *Confirmatory Lab Results Required for Surgery

OTHER ALLERGIES: ____

PAST MEDICAL HISTORY (Include date or year of last episode – If current condition, please note on next page):

_____MRSA (Methicillin Resistant Staph Aureus) _____Other Infectious Process (Specify)_____________________

_____High Blood Pressure _____Heart Attack _____Seizure _____Blood Clot-Leg

_____Congestive Heart Failure _____Stroke _____Bleeding Ulcer ___Right ___Left

_____Cancer: Include location(s) and treatment(s):____

Other:____

SURGERIES (List ALL surgeries and dates) ____

____

____

____

Do You Have Any Metal In Your Body? _____Yes _____No **Do you have a Pacemaker?** _____Yes _____No

INJURIES (Include year) ____

____

SOCIAL:

Tobacco: _____Yes _____No Type:_______________ Quantity____________

Quit (year):__________

Alcohol: _____Yes _____No Quantity ____________

Other Substance: _____Yes _____No Specify:_____________________________

Quit (year):__________ Rehab:______________

FAMILY HISTORY -- If living, give present age and health status. If deceased, give age at death, and cause.

	Living (Current Age)	Deceased (Age when expired)	List any health conditions (and cause of death, if appropriate) i.e. Diabetes, Heart Disease, Cancer, Tuberculosis, etc.
Father			
Mother			
Brothers			
Sisters			
Spouse			
Children			