METROPOLITAN NEUROSURGERY ASSOCIATES, PA

Name: ____ **Date of Birth:** _____________**Age:**_______

(Current problem (briefly state why you are here to see the doctor) __________________________________
____

Medical History:

Current Height: ___________ **Weight**____________ **Right or Left Handed?** _________________

Please review the following list and circle **Yes** or **No** if you have condition

Condition / Disease

Condition			Condition		
Diabetes----------------	Yes	No	High -Blood Pressure------	Yes	No
Pneumonia-------------	Yes	No	Liver Disease-------------	Yes	No
Kidney Disease-------	Yes	No	Heart Attack/Stroke------	Yes	No
Heart Disease---------	Yes	No	Congenital Heart Defect---	Yes	No
Heart Murmur---------	Yes	No	Lung Disease----------------	Yes	No
Asthma -----------------	Yes	No	Rheumatic Fever-------	Yes	No
Anemia------------------	Yes	No	HIV/AIDS-------------------	Yes	No
Hepatitis----------------	Yes	No	Atrial Fibrillation ----------	Yes	No
Cancer------------------	Yes	No	Hemophilia----------------	Yes	No
Arthritis -----------------	Yes	No	Tuberculosis---------------	Yes	No
Osteoporosis-----------	Yes	No	Bleeding Disorders--------	Yes	No
Seizures / epilepsy ---	Yes	No	Cirrhosis----------------------	Yes	No
Endocrine Problems--	Yes	No	Hormone Therapy-----------	Yes	No
Headaches-------------	Yes	No	Pacemaker--------------------	Yes	No
Metal / Latex allergy-	Yes	No			

Other Significant Illnesses for which you have taken medicine and/or have seen a physician
____
____.

(Please list all Surgeries with the approximate dates):

Type of Surgery: **Date:** **Hospital:**

Have you ever had any problems with anesthesia? **YES** **NO**

Allergies: **(**List all medications and health products you have had a bad reaction to and type of reaction)

Medications: (List all medication names including non-prescription medications, vitamins, herbs, or supplements.) Please include the dosage, and how many you take daily (example; Lasix 20 mg 1 tablet daily).

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________
5. ______________________________ 6. ______________________________
7. ______________________________ 8. ______________________________
9. ______________________________ 10. ______________________________

Current Activity Status:

______ Fully active; Normal
______ Have difficulty with strenuous activity; Can do light activities (housework, office work)
______ Unable to work; Can care for self; Out of bed or chair more than 50%
______ Can only do limited self-care; Stay in bed or chair more than 50% of waking hours
______ Cannot do self-care; Confined to bed or chair

1. If you currently have pain, where is it? ____.
2. If you currently have pain, please rate your pain: 0 – 1 - 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
   = NO pain) (10 = worst possible pain)
3. What are you currently doing to relieve your pain? _____________________________________
4. Have you recently had any physical therapy? ____
5. Have you had epidural injections? ____
6. Are current symptoms from a car accident ? Yes No
7. Are current symptoms from a work injury? Yes No

Social History:

1. Marital status (**circle one**): Married / Single / Separated / Divorced / Widowed.
   Do you live alone? (**circle one)** Yes. No.

2. What is your occupation? ________________________________.
   Are you retired? **(circle one)** Yes. No.

3. Do you use tobacco products? (**circle one)** Yes. No. How many years? _______________.
   Have you stopped? **(circle one)** Yes. No. When? __________________________.
   What did you use? (**circle one)** Cigarettes (# of packs/day __________. Cigars. Pipe.
   Chewing tobacco.

4. Do you drink alcohol? **(circle one)** Yes. No. How often?__________________________

5. Do you use recreational (street) drugs? Yes or No
   What type and how often?____

Family History:

Do you have anyone in your immediate family who has been diagnosed with Heart Disease, Diabetes, Cancer, Arthritis, Kidney Disease, Blood Disorders, Blood Clots, etc? Yes. No.
Please list the family member affected and what their condition was?

____

____

____

Female Patients Only: Currently Pregnant: (circle one) Yes. No.
Are you presently taking birth control pills, or other hormones? (**circle one)** Yes. No.

____ ___________________________________
Patient's signature **Date**