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Medical College

Department of Neurological Surgery  
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**PATIENT MEDICAL HISTORY**

Today's Date: \_\_\_\_\_

*Physician Name: Please circle the name of the physician with whom you have an appointment.*

- DR. J. BOOCKVAR      DR. P. GOBIN      DR. R. HARTL      DR. M. KAPLITT      DR. S. PANNULLO  
DR. H. RIINA      DR. SCHWARTZ      DR. M. SOUWEIDANE      DR. P. STIEG      DR. M. ZONENSHAYN

*Patient Information*

Patient Name: \_\_\_\_\_  
(First) (Middle) (Last)  
Home Address: \_\_\_\_\_  
(Street Name and #) (City, State) (Zip Code)  
Phone: \_\_\_\_\_  
(Home) (Business)

*Demographic Information*

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Occupation: \_\_\_\_\_

*Referral Information*

How were you referred to us? WEBSITE      INSURANCE      FAMILY/FRIEND      EMERGENCY ROOM  
OTHER \_\_\_\_\_ BRAIN/SPINE ORGANIZATION: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_

*Health Information*

Reason for today's visit: \_\_\_\_\_  
Other diseases and/or problems:  
(1) \_\_\_\_\_  
(2) \_\_\_\_\_

*Lifestyle Information*

Do you smoke? \_\_\_\_ How many packs a day? \_\_\_\_ How many years? \_\_\_\_ Quit? When \_\_\_\_  
Do you drink alcohol? \_\_\_\_ How often? \_\_\_\_\_ How much? \_\_\_\_\_  
Do you use recreational drugs? \_\_\_\_ Which Drugs? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you exercise regularly? \_\_\_\_ How often? \_\_\_\_\_ What type of exercise? \_\_\_\_\_

**Please indicate if you have any of the following:**

- |                            |  |                              |  |
|----------------------------|--|------------------------------|--|
| Anemia                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV disease                  | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Arthritis                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney/urinary problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Asthma                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Memory loss                  | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Bleeding/clotting disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Numbness or pain in fingers  | <input type="checkbox"/> in toes <input type="checkbox"/> arms <input type="checkbox"/> legs |
| Cancer (Type)              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neuromuscular diseases       | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Chest Pain                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rashes                       | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Depression                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ringling in ears             | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Diabetes                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Difficulty speaking        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/intestinal problem   | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Difficulty swallowing      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke/CVA                   | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Dizziness/fainting         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling arms/legs           | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Emphysema                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thrombophlebitis             | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Fevers                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid/Parathyroid Disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Glaucoma/cataracts         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Transplant (donor/recipient) | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Gout                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                 | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Headaches                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers (GI/Duodenal)         | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Hearing loss               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Unplanned weight loss        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| Heart Disease              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weakness in arms/legs        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                     |
| High Cholesterol           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
| High Blood Pressure        | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |

**Please list any medications you are currently taking:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Are you presently taking aspirin or have you taken aspirin in the past 7 days?**  Yes  No

**Please list any herbal or over-the counter preparations you are currently taking:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

