MedStar Health

MEDSTAR NEUROSURGICAL ASSOCIATES

Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____
Full Street Address: _____
Cell Phone: _____ Home Phone: _____
Email Address: _____ S.S. # _____
Emergency Contact: _____
Relationship_____ Phone: _____

Marital Status: Single Married Divorced Widow Number of Children: _____
Does anyone live at home? Who: _____
Spouses/ S.O. Name: _____ Phone: _____
Work Status: Full Duty Light Duty Not Employed Retired Last day of work_____
Occupation: _____ Employer: _____

Are You? Right Handed ~ Left Handed ~ Ambidextrous Height: _____ Weight: _____
Religious Preference:_____ Race: Hispanic or Non- Hispanic
Ethnicity: Caucasian ~ African American ~ Asian ~ Native American ~ Pacific Island
Served in Armed Forces? Branch: _____Years: ____ Location: _____
Traveled outside of the U.S. in past 3 months? Where: _____ When: _____

Preferred Pharmacy: _____ Address:_____ Zip: _____
REFERRED BY: _____ Phone #: _____
Primary Dr Name/ Address/ Phone: _____
Other Dr Name/ Address/ Phone: _____

WORKERS COMPENSATION

Is this a reported work accident? _____ Auto Accident _____ (need PIP exhaust letter)

Please describe accident: _____

Claim #: _____ Date of Injury: _____Place of work: _____

Work comp company/ adjustors name, Phone: _____

Attorney name and Phone: _____

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Patient Name:_____DOB:_____

Prior Surgeries (Name, Year, Surgeon)

_____

_____

_____

_____

Any problem with Anesthesia: _____

List all current prescriptions medications you are taking: (continue on reverse side if needed)

Medication	Dose/Frequency	How long?	Reason

Do you take a blood thinner or aspirin? Yes No If Yes, Why?_____

List Vitamins, Supplements, Over counter medicines:_____

_____

Allergies to medications and reactions:_____

_____

Allergic to Latex? Yes No reaction:_____

Allergic to Iodine/shellfish? Yes No reaction:_____

Allergic to Band-aids/Adhesive tape? Yes No reaction:_____

Allergic to X-ray Contrast? Yes No reaction:_____

Seasonal/Environmental Allergies:_____

FAMILY HISTORY: (blood relatives only)

Neck or Back Surgery_____

Brain Tumor, Aneurysm, Brain Hemorrhage, Stroke, Seizures_____

Arthritis/Spinal Disorders_____

Bleeding Disorders or Blood Factor Disease_____

Other Family Disease_____

SOCIAL HISTORY/HABITS: (please circle)

Alcohol use: Daily/Every week/Occasional/Rare/Never Amount/Frequency:_____

Tobacco: Cigarettes/Cigars/Chew Yes/No/Quit/Never Amount/Duration:_____

Recreational Drug use: Yes/No/Quit Intravenous Describe_____

Exercise: Type/ Frequency:_____

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Review of Symptoms

(Please circle any positives and describe)

Cancer	Heart Attack	Seizures
Tuberculosis or positive TB test	Pacemaker	Stroke
Blood transfusion	Cardiac Stents	Paralysis
Hepatitis	Heart Valve Problem	Hearing Loss
HIV/AIDS	High Cholesterol	Blindness
Organ Transplant	Irregular Heart Beat	Meningitis
Heart Failure	Chest Pain	Memory Loss
COPD	Unintended Weight Loss	Visual Loss
Emphysema	Excessive Fatigue	Cataracts
Asthma	Night Sweats	Glaucoma
Home Oxygen Use	No Appetite	Double Vision
Sleep Apnea/CPAP	Fever	Glasses/Contacts
Diabetes-Insulin	GERD/Gastritis	Hoarseness
Diabetes-No Insulin	Blood in Stool	Paralyzed Vocal Cord
Low Thyroid	Problems swallowing	Anxiety
High Thyroid	IBS	Depression
Hormone Disorders	Diarrhea	Insomnia
Pituitary Failure	Constipation	Sexual Dysfunction
High Blood Pressure	Abdominal Pain	Mental Health Medications
Blood Clots	Colitis	Hospitalization for Mental Health
DVT-Embolism	Nausea-Vomiting	Bipolar
Peripheral Vascular Stents	Liver Disease	Other Mental Health
Peripheral Vascular Surgery	Crohn's Disease	Anemia
Varicose Veins	Ulcerative Colitis	Other Blood Disease
Low Blood Pressure	Gout	Bleeding Tendency
Major Infections	Osteoarthritis	Facial weakness
Blood in Urine	Rheumatoid Arthritis	Ringing in Ears
Kidney Stones	Psoriasis	Facial pain
Kidney Failure	Eczema	Major Trauma
Dialysis	Other Skin Disorder	Broken Bones
Bladder Problem	Other bone or joint disease	Metal in Body
Prostate Enlargement	Muscle disease or cramps	Joint Replacements
Incontinence	Restless Legs	Chronic Pain
Osteoporosis	Vitamin D Deficiency	Prescription Pain Meds
Osteopenia	Spinal Injuries-Fractures	Loss of Height

Please describe anything above or other active medical concerns:_____

_____