

**DEPARTMENT OF NEUROSURGERY - LONGSTREET CLINIC**

**PATIENT HEALTH INFORMATION**

(Please circle or fill-in all appropriate information on front and back)

Today's Date: \_\_\_/\_\_\_/\_\_\_ Date of Last Physical Exam \_\_\_/\_\_\_/\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Height \_\_\_\_\_' \_\_\_\_\_" \_\_\_\_\_"  
Weight \_\_\_\_\_ lbs Are you left or right handed? \_\_\_\_\_

Chief Complaint \_\_\_\_\_

What is the main reason for your visit today? Describe your problem in detail.

\_\_\_\_\_

**HISTORY OF PRESENT ILLNESS:**

Location of the problem: Left or Right or Both  
Neck Shoulder Arm Elbow Forearm Wrist Hand Finger  
Back Hip Groin Thigh Knee Leg Ankle Foot Toe  
Other: \_\_\_\_\_

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem:

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

\_\_\_\_\_ day(s)/ week(s) / month(s) / year(s) ago

Is the problem due to an injury? Yes / No

If yes, give the date of the injury: \_\_\_\_\_

Does anything make the problem worse? Yes / No

If yes, describe: \_\_\_\_\_

Does anything make the problem better? Yes / No

If yes, describe: \_\_\_\_\_

How long does the problem last at a time?

A few minutes A few hours It is always there

Other: \_\_\_\_\_

How often does the problem occur?

Every Hour Once a day Once a week Always there

Other: \_\_\_\_\_

Does anything else occur at the same time? Yes / No

If yes, describe: \_\_\_\_\_

If there is pain, is it sharp, dull or throbbing?

Describe: \_\_\_\_\_

Does the problem interfere with normal functions? Y N

If yes, describe: \_\_\_\_\_

Is the problem getting worse, or staying the same? \_\_\_\_\_

Have you had this problem before? Yes / No

**PAST MEDICAL AND SOCIAL HISTORY**

List all serious illnesses in your immediate family: (Examples: diabetes, tuberculosis, cancer, heart disease, etc.)

Father: \_\_\_\_\_

Siblings: \_\_\_\_\_

Mother: \_\_\_\_\_

Children: \_\_\_\_\_

List any personal past illnesses and surgeries and when they occurred:

Illness or surgery

Date

\_\_\_\_\_  
\_\_\_\_\_

Do you smoke? Yes / No

If yes, how much? \_\_\_\_\_

Do you drink alcohol? Yes / No

If yes, how much? \_\_\_\_\_

Are you on a special diet? Yes / No

If Yes, explain \_\_\_\_\_

List all allergies to medication: \_\_\_\_\_

Are you on any medications? Yes / No (if yes, list all with dosages)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician Use Only:

Over →

## REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Circle Yes or No.  
Please explain any Yes answers in the space provided.

<b>Constitutional Symptoms</b>		
Fever	Y	N
Chills	Y	N
Headache	Y	N
Other: _____		
<b>Eyes</b>		
Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other: _____		
<b>Allergic/Immunologic</b>		
Hay Fever	Y	N
Drug Allergies	Y	N
Other: _____		
<b>Neurological</b>		
Tremors	Y	N
Dizzy Spells	Y	N
Numbness/tingling	Y	N
Other: _____		
<b>Endocrine</b>		
Excessive Thirst	Y	N
Too hot/cold	Y	N
Tired/Sluggish	Y	N
Other: _____		
<b>Gastrointestinal</b>		
Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/heartburn	Y	N
<b>Cardiovascular</b>		
Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Other: _____		

<b>Integumentary</b>		
Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other: _____		
<b>Musculoskeletal</b>		
Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other: _____		
<b>Ear/Nose/Throat/Mouth</b>		
Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other: _____		
<b>Genitourinary</b>		
Urine infection	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other: _____		
<b>Respiratory</b>		
Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other: _____		
<b>Hematologic</b>		
Swollen glands	Y	N
Blood clotting problem	Y	N
Other: _____		
<b>Psychologic</b>		
Are you happy with your life?	Y	N
Do you feel depressed?	Y	N
Have you considered suicide?	Y	N
Other: _____		

What is your current occupation? \_\_\_\_\_

Who referred you to our clinic today? \_\_\_\_\_

Who is your medical doctor? \_\_\_\_\_

Physician Use only: Comments/Notes
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Physician Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_