MEDSTAR NEUROSURGICAL ASSOCIATES
Patient Information

Date:_____ Patient Name:_____

Full Street Address:_____
Cell Phone: _____ Work Phone: _____ Home Phone: _____
Email Address:_____
Date of Birth:_____ Age:_____SS#:_____

Marital Status: M S W D Number of Children_____
Do you live with anyone at home? Who_____
Emergency Contact:_____Relationship:_____Phone_____

Current Work Status: Working: Full Duty Light Duty Retired
Not Working: Last Day Worked:_____
Occupation:_____
Employer:_____

Height:_____ Weight:_____

S.O./Spouse Name:_____ Spouse Phone:_____
S.O/Spouse Occupation and Employer:_____

Served in Armed Forces? _____ Branch _____Years _____ Location(s) _____

Travel outside US in past 3 months?_____ Where?_____

Race (please circle all that apply): Caucasian African American Asian Hispanic
Native American Pacific Islander

Are you Right Handed Left Handed Ambidextrous

REFERRED BY: _____

Primary Care Doctor name/address & Phone #:_____

Other Doctor name/address & Phone #:_____

If this is an accident, is this a reported work injury?_____Auto injury?_____
If this is an accident, please describe:_____
If you have an attorney name and phone:_____

MEDSTAR NEUROSURGICAL ASSOCIATES

Patient Information

Prior Surgeries (Name, Year, Surgeon)

_____

_____

_____

_____

Any problem with Anesthesia: _____

Major Medical Conditions_____

_____

_____

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: (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:_____

Review of Symptoms

MEDSTAR NEUROSURGICAL ASSOCIATES

Patient Information

(Please circle any positives and describe)

Cancer
Tuberculosis or positive TB test
Blood transfusion
Hepatitis
HIV/AIDS
Organ Transplant
Heart Failure
COPD
Emphysema
Asthma
Home Oxygen Use
Sleep Apnea/CPAP
Diabetes-Insulin
Diabetes-No Insulin
Low Thyroid
High Thyroid
Hormone Disorders
Pituitary Failure
High Blood Pressure
Blood Clots
DVT-Embolism
Peripheral Vascular Stents
Peripheral Vascular Surgery
Varicose Veins
Low Blood Pressure
Major Infections
Blood in Urine
Kidney Stones
Kidney Failure
Dialysis
Bladder Problem
Prostate Enlargement
Incontinence
Osteoporosis
Osteopenia

Heart Attack
Pacemaker
Cardiac Stents
Heart Valve Problem
High Cholesterol
Irregular Heart Beat
Chest Pain
Unintended Weight Loss
Excessive Fatigue
Night Sweats
No Appetite
Fever
GERD/Gastritis
Blood in Stool
Problems swallowing
IBS
Diarrhea
Constipation
Abdominal Pain
Colitis
Nausea-Vomiting
Liver Disease
Crohn's Disease
Ulcerative Colitis
Gout
Osteoarthritis
Rheumatoid Arthritis
Psoriasis
Eczema
Other Skin Disorder
Other bone or joint disease
Muscle disease or cramps
Restless Legs
Vitamin D Deficiency
Spinal Injuries-Fractures

Seizures
Stroke
Paralysis
Hearing Loss
Blindness
Meningitis
Memory Loss
Visual Loss
Cataracts
Glaucoma
Double Vision
Glasses/Contacts
Hoarseness
Paralyzed Vocal Cord
Anxiety
Depression
Insomnia
Sexual Dysfunction
Mental Health Medications
Hospitalization for Mental Health
Bipolar
Other Mental Health
Anemia
Other Blood Disease
Bleeding Tendency
Facial weakness
Ringing in Ears
Facial pain
Major Trauma
Broken Bones
Metal in Body
Joint Replacements
Chronic Pain
Prescription Pain Meds
Loss of Height

Please describe anything above or other active medical concerns:_____

_____

_____