NEW NEUROSURGEY PATIENT

Hartford HealthCare

Name: _____ _____
Last First, MI

Age: _____ Sex: _____ Date of Birth: _____ Are you Right or Left-handed?: □Right □Left

Height: _____ Weight: _____ Referring Physician: _____

What is the reason for your visit today? _____

When did this start? _____ Has this happened before?: □No □Yes When?:_____

How did it start?: _____

_____

Has it changed since then?: □No □Yes. If Yes, How has it changed?:_____

_____

Have you seen another physician for this problem? □No □Yes. If Yes, who?: _____

What work-up has been done for this problem?:

□ X-rays – of the _____ on _____ at _____ □ I have them on a CD
body part date institution

□ CT scan – of the _____ on _____ at _____ □ I have them on a CD
body part date institution

□ MRI – of the _____ on _____ at _____ □ I have them on a CD
body part date institution

□ _____ - of the _____ on _____ at _____ □ I have them on a CD
other body part date institution

<u>Past History:</u>

Do you have a personal history of cancer or tumors?: □No □Yes

If Yes, please relate details of diagnosis and prior treatments:_____

_____

_____

Do you have a personal history of any disease or condition relating to today's visit?: □No □Yes

If Yes, please relate details of diagnosis and prior treatments:_____

_____

_____

Past medical history: Do you have a history of any of the following?:
□high blood pressure □heart disease _____
□diabetes □lung disease _____
Are you allergic to any medications or medical dyes? □No □Yes. If yes, list: _____
Are you currently taking any medications that may thin your blood? □No. □Aspirin
□Plavix (clopidogrel) □Coumadin (warfarin) □Eliquis (apixaban) □Xarelto (rivaroxiban)
□Pradaxa (dabagatran) □Other_____

Past surgical history: Have you had prior surgery on your brain or spine? □No □Yes.
If yes, explain: _____

Family history: have any of the following been diagnosed in a first-degree relative (parent, sibling, child)?
□ none □brain tumor □brain aneurysm/AVM □spinal tumor

Social History: Occupation: _____
Do you use tobacco?: □No □Yes. If yes, how?:_____ Amount daily:_____
Do you drink alcohol?: □No □Yes. If yes, amount daily?:_____

Review of Systems: Do you have any of the following problems?:

- □ Fever
- □ Infection
- □ Heat intolerance
- □ Cold intolerance
- □ Blurred vision
- □ Double vision
- □ Headache
- □ Change in hearing
- □ Change in taste or smell
- □Difficulty swallowing
- □ Change in voice
- □ Persistent cough
- □ Shortness of breath
- □ Chest pain
- □ Irregular heart beat
- □ Abdominal pain
- □ Nausea
- □ Vomiting
- □ Bowel incontinence
- □ Bladder incontinence
- □ Sexual dysfunction
- □ Back pain
- □ Neck pain
- □ Joint pain
- □ Skin easily bruises
- □ Excessive bleeding
- □ Difficulty clotting blood
- □ Anxiety
- □ Depression
- □ Numbness
- □ Tingling
- □ Weakness
- □ Seizures
- □ Loss of feeling around groin, genitals, buttocks

Patient signature: _____ Date: _____

Notes:
_____
_____
_____
_____