Washington University in St. Louis Physicians

Welcome!

Neurosurgery Department at Washington University
Cranial Health History Form

To help us treat you, please fill this form out completely.

Your Name _____ Today's Date ___/___/___

Your Age _____ Date of Birth ___/___/___

Are you (please √ one): ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

PHYSICIANS

Who referred you to us

Name of Doctor _____

Fax Number _____

Primary Care Physician

If same as referring, check here: ☐

Name of Doctor _____

Fax Number _____

List any other physicians you would like us to send our notes to:

Name of Doctor _____

Fax Number _____

Name of Doctor _____

Fax Number _____

Name of Doctor _____

Fax Number _____

WHAT PROBLEM ARE WE SEEING YOU FOR TODAY?

_____

_____

_____

_____

PAST MEDICAL HISTORY

Neurological Problems If none, check here: ☐

TIA (Transient ischemic attack)	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Brain bleed (intracerebral hemorrhage)	☐ Yes	☐ No
Brain aneurysm	☐ Yes	☐ No
Brain vascular malformation (AVM, cavernous malformation)	☐ Yes	☐ No
Brain tumor (brain neoplasm)	☐ Yes	☐ No
Narrowing of carotid arteries (carotid artery stenosis)	☐ Yes	☐ No
Seizures (convulsions)	☐ Yes	☐ No
Dementia/Alzheimer's Disease	☐ Yes	☐ No
Cervical disc disease	☐ Yes	☐ No
Cervical stenosis	☐ Yes	☐ No
Lumbar disc disease	☐ Yes	☐ No
Lumbar stenosis	☐ Yes	☐ No

Heart problems If none, check here: ☐

Chest pain (angina, coronary artery disease)	☐ Yes	☐ No
Heart Attack (myocardial infarction)	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No
High blood pressure (hypertension)	☐ Yes	☐ No
Aortic insufficiency	☐ Yes	☐ No
Mitral valve regurgitation	☐ Yes	☐ No
Atrial fibrillation	☐ Yes	☐ No
Mitral valve prolapse	☐ Yes	☐ No

Lung problems If none, check here: ☐

Emphysema (COPD)	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No

Endocrine problems If none, check here: ☐

High thyroid levels (hyperthyroidism)	☐ Yes	☐ No
Low thyroid levels (hypothyroidism)	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No

PAST MEDICAL HISTORY continued

GI problems (stomach, colon) If none, check here: ☐
Ulcers (peptic ulcer disease) ☐ Yes ☐ No
Reflux (gastroesophageal reflux disease) ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Liver failure ☐ Yes ☐ No
Diverticulosis ☐ Yes ☐ No

Kidney/Bladder/ Prostate problems If none, check here: ☐
Urinary infections (urinary tract infections) ☐ Yes ☐ No
Kidney infections (pyelonephritis) ☐ Yes ☐ No
Kidney dysfunction – no dialysis (renal insufficiency) ☐ Yes ☐ No
Kidney dysfunction – dialysis (renal failure) ☐ Yes ☐ No
Polycystic kidney disease ☐ Yes ☐ No
Prostate enlargement (benign prostatic hypertrophy) ☐ Yes ☐ No

Blood problems If none, check here: ☐
Bleeding disorder ☐ Yes ☐ No
Deep vein thrombosis ☐ Yes ☐ No
Pulmonary Embolus ☐ Yes ☐ No
Taking blood thinner (coumadin, warfarin, aspirin, etc.) ☐ Yes ☐ No

Immune problems If none, check here: ☐
HIV ☐ Yes ☐ No
AIDS ☐ Yes ☐ No

Psychiatric Problems If none, check here: ☐
Depression ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Bipolar disorder ☐ Yes ☐ No
Psychosis ☐ Yes ☐ No

Cancer If none, check here: ☐
Lung ☐ Yes ☐ No
Thyroid ☐ Yes ☐ No
Breast ☐ Yes ☐ No
Colon ☐ Yes ☐ No
Pancreas ☐ Yes ☐ No
Prostate ☐ Yes ☐ No
Kidney ☐ Yes ☐ No
Melanoma ☐ Yes ☐ No

Other Problems If none, check here: ☐
Rheumatoid Arthritis ☐ Yes ☐ No
Marfan's disease ☐ Yes ☐ No
Polyarteritis Nodosa ☐ Yes ☐ No
Previous history of radiation ☐ Yes ☐ No
What part of body _____
Previous history of chemotherapy ☐ Yes ☐ No
What type _____
Women of childbearing age
Possible pregnancy ☐ Yes ☐ No

Please list other active medical problems not noted above (These are problems for which you are currently taking medication or are seeing another physician):

_____

_____

PAST SURGICAL HISTORY

If none, check here: ☐

Surgery			Year(s)
Brain surgery (craniotomy)	☐ Yes	☐ No	_____
Shunt	☐ Yes	☐ No	_____
Spinal surgery – neck (cervical)	☐ Yes	☐ No	_____
Spinal surgery – low back (lumbar)	☐ Yes	☐ No	_____
Cataract surgery ☐ left ☐ right	☐ Yes	☐ No	_____

Surgery			Year(s)
Heart bypass (CABG)	☐ Yes	☐ No	_____
Heart valve replacement	☐ Yes	☐ No	_____
Heart stent (angioplasty and stent)	☐ Yes	☐ No	_____
Appendectomy	☐ Yes	☐ No	_____
Cholecystectomy	☐ Yes	☐ No	_____
Tonsillectomy	☐ Yes	☐ No	_____

PAST SURGICAL HISTORY continued

Please list other surgeries:

Type of/Reason For Surgery	Year	Type of/Reason For Surgery	Year

MEDICATIONS

Please list all medications you are taking, including over-the-counter medications such as aspirin/ibuprofen and herbal medications.

Name of Medication	Dose/Frequency	Name of Medication	Dose/Frequency

ALLERGIES

Please list all medication and non-medication allergies. If none, check here: ☐

Do you have an allergy to latex? ☐ Yes ☐ No ☐ Unknown

FAMILY HISTORY

Please indicate any major medical problems in your family. If none, check here: ☐

Brain aneurysm ☐ Yes ☐ No
☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister ☐ brother ☐ child

Cavernous malformation ☐ Yes ☐ No
☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister ☐ brother ☐ child

Hereditary Hemorrhagic Telangiectasia ☐ Yes ☐ No
☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister ☐ brother ☐ child

Neurofibromatosis ☐ Yes ☐ No ☐ Type I ☐ Type II
☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister ☐ brother ☐ child

Von Hippel-Lindau disease ☐ Yes ☐ No
☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister ☐ brother ☐ child

Brain tumor ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Hypertension ☐ Yes ☐ No

Heart disease/heart attack ☐ Yes ☐ No

FAMILY HISTORY continued

Other family medical history

_____

_____

_____

PERSONAL/SOCIAL HISTORY

Your Height: _____ feet _____ inches **Weight:** _____ pounds

Do you drink alcohol? ☐ No, never drank ☐ No, but did in the past Year Quit _____
☐ Yes (Check all that apply) ☐ Beer ☐ Wine ☐ Mixed Drinks ☐ Straight Liquor/Shots
How many drinks do you have in the average week? _____

Do you use tobacco? ☐ No, never ☐ No, but did in the past Year Quit _____
☐ Yes (Check all that apply) ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Pipe
How many cigarettes / cigars per day? _____

Have you ever used illegal drugs? ☐ No ☐ Yes (Check all that apply)
☐ Cocaine ☐ Marijuana ☐ Other _____

Marital Status

☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Work Status

☐ Currently employed
Occupation _____
☐ Not currently employed
☐ Retired
☐ On disability
When disabled? _____
Reason for disability? _____

REVIEW OF SYSTEMS Have you recently had any of the following symptoms?

☐ Yes	☐ No	Tiredness/fatigue	☐ Yes	☐ No	Cough
☐ Yes	☐ No	Fevers	☐ Yes	☐ No	Heartburn (acid reflux)
☐ Yes	☐ No	Chills	☐ Yes	☐ No	Nausea
☐ Yes	☐ No	Sweat heavily at night (night sweats)	☐ Yes	☐ No	Vomiting
☐ Yes	☐ No	Recent weight loss (unintentional)	☐ Yes	☐ No	Easy bleeding
☐ Yes	☐ No	Headache	☐ Yes	☐ No	Easy bruising
☐ Yes	☐ No	Chest pain	☐ Yes	☐ No	Diffuse joint pains (arthralgia)
☐ Yes	☐ No	Palpitations (heart racing)	☐ Yes	☐ No	Muscle aches
☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No	Anxiety
☐ Yes	☐ No	Difficulty breathing during physical activity	☐ Yes	☐ No	Depression

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

Is this a workman's compensation case?	☐ Yes	☐ No
Is this related to an injury or car accident?	☐ Yes	☐ No
Are you currently involved in any litigation or lawsuits?	☐ Yes	☐ No
Have you consulted a lawyer about your injury/problem?	☐ Yes	☐ No