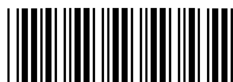


Washington University in St. Louis
Physicians

Welcome!

Washington University School of Medicine
Department of Neurological Surgery
Patient Health History Form

Patient's Name ____________________ Date of Visit ___/___/___

Home Phone ____________________ Work Phone ____________________ Date of Birth ___/___/___

Neurosurgeon ____________________

Age ________ Dominant Hand: ☐ Right ☐ Left

PHYSICIANS

Referring Physician

Name ____________________

Address ____________________

City, State, ZIP ____________________

Phone ____________________

Do you want us to notify this physician of your visit?

☐ Yes ☐ No

Primary Care Physician

Name ____________________

Address ____________________

City, State, ZIP ____________________

Phone ____________________

CHIEF COMPLAINT (Brief summary of the reason for your visit):

____

____

____

____

PROOF

PAST SURGERIES

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

CHRONIC MEDICAL CONDITIONS (For example diabetes, hypertension, heart disease):

____

____

ENVIRONMENTAL ALLERGIES

____

____

MEDICATION ALLERGIES

____

____

WASHU NEURO GENHIST A NL (Rev 10/12)

Dr. Michael Chicoine

Dr. Ralph Dacey

Dr. Joshua Dowling

Dr. Robert Grubb, Jr.

Dr. Albert Kim

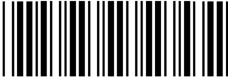
Dr. Eric Leuthardt

Dr. Keith Rich

Dr. Paul Santiago

Dr. Todd Stewart

Dr. Neill Wright



CURRENT MEDICATIONS

If you take more medicines than the space allotted, please list the rest on the back of this sheet.

Name of Medicine	Dosage/Frequency	Reason for Taking	Prescribing MD

FAMILY MEDICAL HISTORY (What illnesses run in your family):

Illness	Relationship to You	Illness	Relationship to You

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children: Male(s) – List Ages ____________________ Female(s) – List Ages ____________________

Occupation ____

BACKGROUND INFORMATION

Complaint related to an injury? ☐ Yes ☐ No Litigation pending? ☐ Yes ☐ No

Workman's Compensation? ☐ Yes ☐ No Other physicians seen for problem? ☐ Yes ☐ No

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 ____________

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

REVIEW OF SYSTEMS

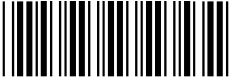
Place an "X" in the appropriate box if the patient has been diagnosed with any of the following illnesses:

Neurological Problems (Brain/Spine)

Stroke ☐ Yes ☐ No
Seizures ☐ Yes ☐ No
Tumor ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Disc Disease ☐ Yes ☐ No

Cardiovascular Problems (Heart)

Chest Pain ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
Heart Attack ☐ Yes ☐ No
Congestive Heart Failure ☐ Yes ☐ No
Mitral Valve Prolapse ☐ Yes ☐ No



REVIEW OF SYSTEMS continued

Respiratory Problems (Lungs)

Shortness of Breath	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No

Endocrine Problems (Hormones)

Thyroid	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No

Gastrointestinal Problems (Stomach/Colon)

Peptic Ulcers	☐ Yes	☐ No
Diverticulosis	☐ Yes	☐ No
Rectal Bleeding	☐ Yes	☐ No

Genitourinary Problems (Kidney/Bladder)

Renal Dysfunction	☐ Yes	☐ No
Kidney Infections	☐ Yes	☐ No
Urinary Tract Infections	☐ Yes	☐ No
Dermatology Problems (Skin)	☐ Yes	☐ No
Ophthalmology Problems (Eye)	☐ Yes	☐ No
Hematological Problems (Blood)	☐ Yes	☐ No
Bleeding Problems	☐ Yes	☐ No

Otolaryngology Problems (Ear, Nose, and Throat)

Ear Infections	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No

Musculoskeletal Problems (Arthritis)

Connective Tissue Disease	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No
Osteoarthritis	☐ Yes	☐ No

Psychiatric Problems

Depression	☐ Yes	☐ No

Other

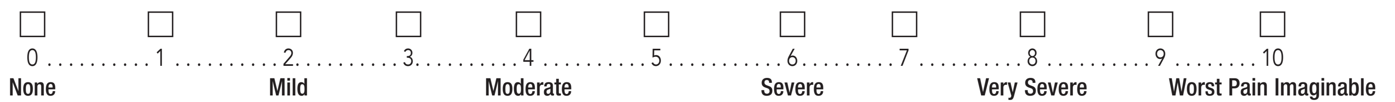
Risk for Exposure to HIV	☐ Yes	☐ No
Past History of Hepatitis	☐ Yes	☐ No
Past Blood Transfusions	☐ Yes	☐ No

Women of Childbearing Age

Possible Pregnancy	☐ Yes	☐ No

DESCRIPTION OF NECK OR BACK PROBLEMS (If applicable)

Rate the intensity of your pain by placing an "X" in a box below.



What procedures have you had for the treatment of your current problem? Please check all that apply.

☐ Surgery	☐ Nerve Blocks	☐ Steroid Injections
☐ Physical Therapy	☐ Tens Unit	☐ Psychological Counseling
☐ Relaxation Training	☐ Biofeedback	☐ Chiropractic Treatment

Please mark your sensations on the figure below using these symbols:

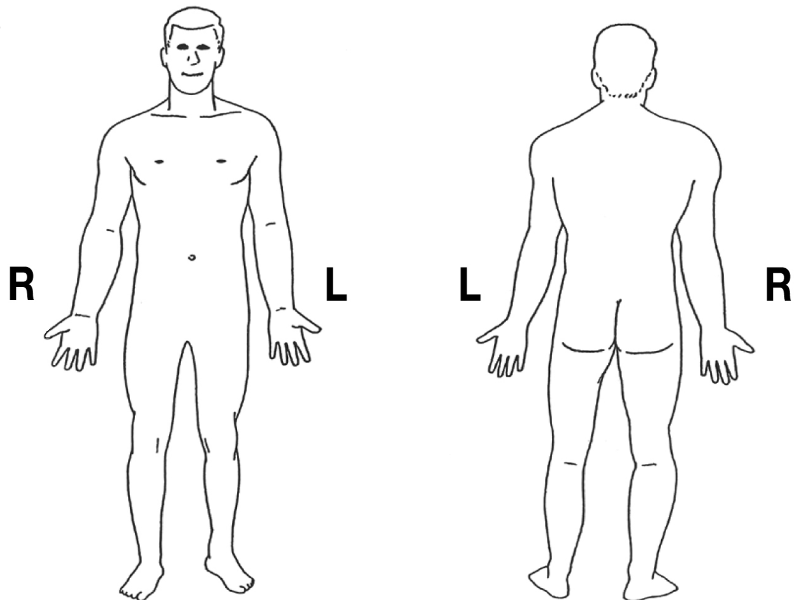
- - - - - - -
Numbness

o o o o o o
Pins/Needles

x x x x x
Burning

/ / / / / /
Stabbing

+ + + +
Aching



Patient/Parent or Guardian Signature ______________________ Date of Visit ____ / ____ / ____