WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

Cranial Health History Form

Welcome to the Neurosurgery Department at Washington University. To help us treat you, please fill this form out completely.

Your Name:_____ **Today's Date:** _____

Your date of birth: _____ **Your age:** _____

Are you: ☐ **right-handed** ☐ **left-handed** ☐ **ambidextrous**

Who referred you to us: _____
Who is your primary care physician? **If same as referring, check here:** ☐

_____

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

_____

_____

What problem are we seeing you for today:

_____

_____

Past Medical History

Neurological problems:	**If none, check here:** ☐	**YES**	**NO**
TIA (transient ischemic attack)		☐	☐
Stroke		☐	☐
Brain bleed (intracerebral hemorrhage)		☐	☐
Brain aneurysm		☐	☐
Brain vascular malformation (AVM, cavernous malformation)		☐	☐
Brain tumor (brain neoplasm		☐	☐
Narrowing of carotid arteries (carotid artery stenosis)		☐	☐
Seizures (convulsions)		☐	☐
Dementia/Alzheimer's Disease		☐	☐
Cervical disc disease		☐	☐
Cervical stenosis		☐	☐
Lumbar disc disease		☐	☐
Lumbar stenosis		☐	☐
Heart problems:	**If none, check here:** ☐		
Chest pain (angina, coronary artery disease)		☐	☐
Heart Attack (myocardial infarction)		☐	☐
Congestive Heart Failure		☐	☐
High blood pressure (hypertension)		☐	☐
Aortic insufficiency		☐	☐
Mitral valve regurgitation		☐	☐
Atrial fibrillation		☐	☐
Mitral valve prolapse		☐	☐

		YES	NO
Lung problems:	**If none, check here: ☐**		
Emphysema (COPD)		☐	☐
Asthma		☐	☐
Tuberculosis		☐	☐
Endocrine problem:	**If none, check here: ☐**		
High thyroid levels (hyperthyroidism)		☐	☐
Low thyroid levels (hypothyroidism)		☐	☐
Diabetes		☐	☐
GI problems (stomach, colon):	**If none, check here: ☐**		
Ulcers (peptic ulcer disease)		☐	☐
Reflux (gastroesophageal reflux disease)		☐	☐
Hepatitis.		☐	☐
Liver failure		☐	☐
Diverticulosis		☐	☐
Kidney / bladder / prostate problems:	**If none, check here: ☐**		
Urinary infections (urinary tract infections)		☐	☐
Kidney infections (pyelonephritis)		☐	☐
Kidney dysfunction – no dialysis (renal insufficiency)		☐	☐
Kidney dysfunction – dialysis (renal failure)		☐	☐
Polycystic Kidney Disease		☐	☐
Prostate enlargement (benign prostatic hypertrophy)		☐	☐
Blood problems:	**If none, check here: ☐**		
Bleeding disorder		☐	☐
Deep vein thrombosis.		☐	☐
Pulmonary Embolus.		☐	☐
Taking blood thinner (coumadin, warfarin, aspirin, etc.)		☐	☐
Immune problems:	**If none, check here: ☐**		
HIV		☐	☐
AIDS		☐	☐
Psychiatric problems:	**If none, check here: ☐**		
Depression		☐	☐
Anxiety		☐	☐
Bipolar disorder		☐	☐
Psychosis		☐	☐
Cancer:	**If none, check here: ☐**		
Lung		☐	☐
Thyroid		☐	☐
Breast		☐	☐
Colon		☐	☐
Pancreas		☐	☐
Prostate		☐	☐
Kidney		☐	☐
Melanoma		☐	☐
Other problems:	**If none, check here: ☐**		
Rheumatoid Arthritis		☐	☐
Marfan's disease		☐	☐
Polyarteritis Nodosa		☐	☐
Possible pregnancy (women of childbearing age)		☐	☐

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

Surgeries:	**If none, check here: ☐**		**YES**	**NO**	**DATE(S)**
Brain surgery (craniotomy)			☐	☐	_____
Shunt	☐	☐	_____		
Spinal surgery – neck (cervical)	☐	☐	_____		
Spinal surgery – low back (lumbar)	☐	☐	_____		
Cataract surgery (☐ left; ☐ right)	☐	☐	_____		
Heart bypass (CABG)	☐	☐	_____		
Heart valve replacement	☐	☐	_____		
Heart stent (angioplasty and stent)	☐	☐	_____		
Appendectomy	☐	☐	_____		
Cholecystectomy	☐	☐	_____		
Tonsillectomy	☐	☐	_____		

Please list other surgeries: _____

_____

_____

Medications: (please list all medications you are taking, including over-the-counter medications such as aspirin, ibuprofen, herbal medications, etc.)

Name	**Dose**	**Name**	**Dose**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: (Please list all medication and non-medication allergies.)

If none, check here: ☐

_____

_____

	YES	**NO**	**UKNOWN**
Do you have an allergy to latex?	☐	☐	☐

Family history: (please indicate any major medical problems in your family)

If none, check here: ☐

	Yes	No
Brain aneurysm	☐	☐
☐ grandmother; ☐ grandfather; ☐ mother; ☐ father; ☐ sister; ☐ brother; ☐ child		
Cavernous malformation	☐	☐
☐ grandmother; ☐ grandfather; ☐ mother; ☐ father; ☐ sister; ☐ brother; ☐ child		
Hereditary Hemorrhagic Telangiectasia	☐	☐
☐ grandmother; ☐ grandfather; ☐ mother; ☐ father; ☐ sister; ☐ brother; ☐ child		
Neurofibromatosis (☐ Type I; ☐ Type II)	☐	☐
☐ grandmother; ☐ grandfather; ☐ mother; ☐ father; ☐ sister; ☐ brother; ☐ child		
Von Hippel-Lindau disease	☐	☐
☐ grandmother; ☐ grandfather; ☐ mother; ☐ father; ☐ sister; ☐ brother; ☐ child		
Brain tumor	☐	☐
Stroke	☐	☐
Hypertension	☐	☐
Heart disease/heart attack	☐	☐

Other family medical history: _____
_____
_____

Personal / social history:

Your height: _____ Your weight: _____

Tobacco use: ☐ Never
- ☐ Previously used
  - Year when you quit: _____
  - Packs/day when using: _____
- ☐ Recently quit
  - Packs/day when using: _____
- ☐ Current:
  - Number of years using: _____
  - Packs/day now using: _____
- ☐ Other nicotine use (chewing tobacco, cigar, pipe)

Alcohol use:
- ☐ Never/rarely
- ☐ Occasionally/socially
- ☐ Moderate (2 drinks/day on average)
- ☐ Heavy (more than 2 drinks/day on average)

Martial status:
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Widowed
- ☐ Divorced

Work status: ☐ Currently employed

- **Occupation: _____**

☐ **Not currently employed**
☐ **Retired**
☐ **On disability**

- **When disabled? _____**
- **Reason for disability? _____**

<u>Review of systems:</u> Have you recently had any of the following symptoms?:

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

<u>Please answer yes or no to the following:</u>

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

_____ _____

Physician Signature **Date**