WASHINGTON UNIVERSITY SCHOOL OF MEDICINE
DEPARTMENT OF NEUROLOGICAL SURGERY
PATIENT HEALTH HISTORY FORM

Date of Visit:_____

Dr. Michael Chicoine	Dr. Albert Kim	Dr. Todd Stewart
Dr. Ralph Dacey	Dr. Eric Leuthardt	Dr. Neill Wright
Dr. Joshua Dowling	Dr. Keith Rich	Dr. Greg Zipfel
Dr. Robert Grubb, Jr.	Dr. Paul Santiago	

Patient Name: _____ **Date of Birth:**_____

Neurosurgeon: _____ **Telephone: Home** _____

Age_____ **Dominant Hand:** ☐**Right** ☐**Left** **Work** _____

Referring Physician:

Name _____

Address_____

_____

Phone Number _____

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

Primary Physician:

Name_____

Address _____

_____

Phone Number _____

Chief Complaint (brief summary of the reason for your visit): _____

_____

MEDICAL HISTORY

Past Surgeries: _____

_____

Chronic Medical Illnesses: _____

_____

Environmental Allergies: _____

Medication Allergies: _____

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

Name	Dosage Frequency	Reason for Taking

Family Medical History (What illnesses run in your family): _____

_____

_____

Social History

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**
Number of Children: _____
Occupation: _____

Background Information	Yes	No
Complaint related to an injury?	☐	☐
Workman's Compensation?	☐	☐
Litigation pending?	☐	☐
Other physicians seen for problem?	☐	☐

Review of Systems
Drink alcohol? ☐ **Never** ☐ **Occasionally** ☐ **Frequently**
Do you smoke cigarettes? ☐ **Yes** ☐ **No** **If yes, how many packs per day?** _____
Height _____ **Weight** _____

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

Neurological Problems (Brain/Spine)	Yes	No
Stroke	☐	☐
Seizures	☐	☐
Tumor	☐	☐
Arthritis	☐	☐
Disc Disease	☐	☐

Cardiovascular Problems (Heart)		
Chest Pain	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Congestive Heart Failure	☐	☐
Mitral Valve Prolapse	☐	☐

	Yes	No
Respiratory Problems (Lungs)		
Shortness of Breath	☐	☐
Tuberculosis	☐	☐
Endocrine Problems (Hormones)		
Thyroid	☐	☐
Diabetes	☐	☐
Gastrointestinal Problems (Stomach/Colon)		
Peptic Ulcers	☐	☐
Diverticulosis	☐	☐
Rectal Bleeding	☐	☐
Genitourinary Problems (Kidney/Bladder)		
Renal Dysfunction	☐	☐
Kidney Infections	☐	☐
Urinary Tract Infections	☐	☐
Dermatology Problems (Skin)	☐	☐
Ophthalmology Problems (Eye)	☐	☐
Hematological Problems (Blood)		
Bleeding Problems	☐	☐
Otolaryngology Problems (Ear, Nose, and Throat)		
Ear Infections	☐	☐
Sinus Problems	☐	☐
Musculoskeletal Problems (Arthritis		
Connective Tissue Disease	☐	☐
Rheumatoid Arthritis	☐	☐
Osteoarthritis	☐	☐
Psychiatric Problems		
Depression	☐	☐
Risk for Exposure to HIV	☐	☐
Past History of Hepatitis	☐	☐
Past Blood Transfusions	☐	☐
Possible Pregnancy (Women of Childbearing Age)	☐	☐

_____ _____

Signature of Patient/Parent or Guardian **Today's Date**

Description of Neck or Back Problems (if applicable)

Rate the intensity of your pain by placing an "X" on the line below.

No Pain **Worst pain imaginable**

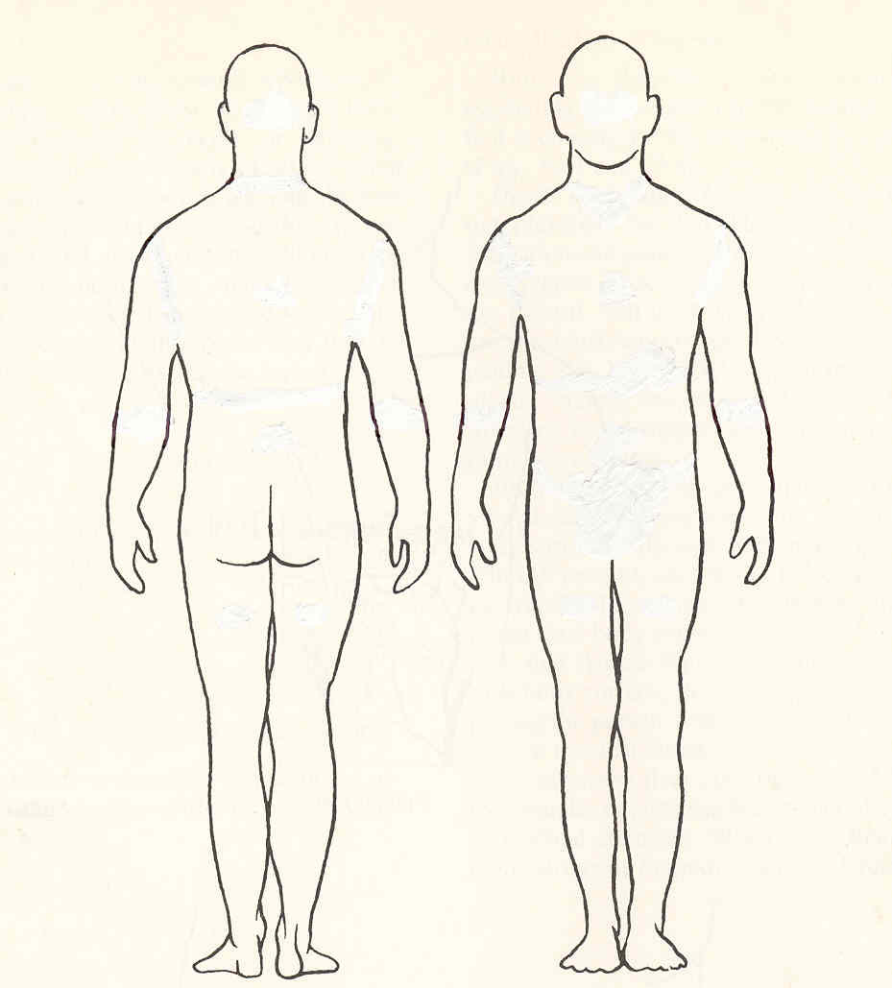
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

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:

- - - - - - - -	o o o o o o o	x x x x x	/ / / / / / /	+ + + +
Numbness	**Pins/Needles**	**Burning**	**Stabbing**	**Aching**



Physician Signature _____ Date _____