NAME _____

DATE _____

OCCUPATION _____

AGE: _____

REASON FOR CONSULTING NEUROSURGEON AT THIS TIME:

_____

_____

_____

HEIGHT _____

WEIGHT _____

When did symptoms start? _____

Have you ever had same or similar symptoms? _____

If you were disabled from work due to this illness - Give dates:

_____

PAST MEDICAL HISTORY:
Operations (surgery) - give year

1. _____
2. _____
3. _____
4. _____

SERIOUS INJURIES OR ACCIDENTS:
give year

1. _____
2. _____
3. _____

OTHER **ILLNESS** OR **HOSPITALIZATION** NOT LISTED ABOVE WITH YEAR (EXCLUDE THE USUAL CHILDHOOD DISEASES UNLESS COMPLICATED).

1. _____
2. _____
3. _____
4. _____

LIST **MEDICATIONS** OR OTHER TREATMENTS THAT YOU ARE NOW TAKING (OR WRITE NONE).

1. _____
2. _____
3. _____
4. _____

FAMILY HISTORY:		**AGE:**	**ILLNESS OR CAUSE OF DEATH**
FATHER	living		
	deceased		
MOTHER	living		
	deceased		

Living Brothers & Sisters _____

_____

Deceased Brothers & Sisters _____

_____

ALLERGIES TO DRUGS, FOOD, POLLENS, ETC.
(DESCRIBE THE TYPE OF REACTION)

_____

_____

_____

IS THERE A HISTORY IN YOUR FAMILY OF:

Diabetes ..... NO YES
Heart Attack ..... NO YES
Stroke ..... NO YES
Cancer or Leukemia ..... NO YES
Tuberculosis ..... NO YES
Nervous Breakdown ..... NO YES
Bleeding Disorder ..... NO YES

MISCELLANEOUS HISTORY:

Cigarettes (packs per day)? _____
Coffee, tea, coke (cups per day) _____
Alcoholic beverages (drinks per day) _____

(over please)

DURING THE PAST TWO MONTHS HAVE YOU:

Lost or gained weight? (How much?) _____
Been persistently tired? _____
Had chills or fever? _____
Been depressed, sad, or unhappy? _____
Been nervous or easily upset? _____
Been unable to sleep well? _____

DURING THE PAST YEAR HAVE YOU HAD:

Persistent or severe headaches? ..... NO YES
Dizziness? ..... NO YES
Eye trouble? ..... NO YES
Hearing trouble? ..... NO YES
Nose Bleeds? ..... NO YES
A sore in your mouth or tongue? ..... NO YES

HAVE YOU HAD:

Shortness of breath? ..... NO YES
Chest pains or tightness? ..... NO YES
Asthma or wheezing? ..... NO YES
Persistent cough? ..... NO YES
Blood spitting? ..... NO YES
Abnormal chest x-ray? ..... NO YES

HAVE YOU EVER HAD:

Heart trouble (or coronary attack)? ..... NO YES
High blood pressure? ..... NO YES
A stroke? ..... NO YES
An abnormal electrocardiogram (EKG)? ..... NO YES
Irregular or rapid heart beat? ..... NO YES
Swollen legs or feet? ..... NO YES
Cold feet? ..... NO YES
Phlebitis or varicose veins? ..... NO YES
Tendency to bleed excessively? ..... NO YES

HAVE YOU HAD:

Kidney trouble? ..... NO YES
Burning or pain when you urinate? ..... NO YES
Trouble passing urine? ..... NO YES
Cloudy or bloody urine? ..... NO YES
To get up at night to urinate? ..... NO YES

HAVE YOU HAD:

Back pain? ..... NO YES
Stiff neck? ..... NO YES
Painful or stiff joints? ..... NO YES
Pain in your legs? ..... NO YES
Morning stiffness? ..... NO YES

DO YOU HAVE:

Poor appetite? ..... NO YES
Trouble swallowing? ..... NO YES
Pains in the stomach? ..... NO YES
Belching or gas? ..... NO YES
Indigestion? ..... NO YES
Heartburn? ..... NO YES
Constipation? ..... NO YES
Diarrhea? ..... NO YES
Swollen abdomen? ..... NO YES
Blood in the stool? ..... NO YES
Black bowel movements? ..... NO YES

FOR WOMEN ONLY:

Have you stopped menstruating? ..... NO YES
Are your periods abnormal? ..... NO YES
Do you have a vaginal discharge? ..... NO YES
When did you have your last internal examination? (Pap Test)? _____