NEUROSURGERY ARKANSAS
ADULT HEALTH HISTORY

THIS IS A CONFIDENTIAL RECORD. INFORMATION CONTAINED HERE CANNOT BE RELEASED WITHOUT YOUR PERMISSION.

Name:_____ Date:_____

Main reason for today's visit:_____

Who is your primary care provider? _____

What is your height?_____ How much do you weigh:_____

PHARMACY: Please list your pharmacy and include address and phone number

_____

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, herbal treatments. Please add an additional page for your medications if needed.

Medication	Dose	How many times per day?

ALLERGIES: Please list medication allergies and type of reaction.

___ I have no medication allergies

Allergy	Type of reaction

REVIEW OF SYSTEMS: Please mark the box and/or circle any continual symptom you have had in the past few months. Read through every section and mark "no problems" if none of the symptoms apply to you.

General/Constitutional
- ____ Chills
- ____ Fatigue
- ____ Fever
- ____ Malaise
- ____ Night sweats
- ____ Unexplained weight gain
- ____ Unexplained weight loss
- ____ Other: _____

_____

Head/eyes/ears/nose/throat
- ____ Ear drainage
- ____ Ear pain
- ____ Eye discharge
- ____ Eye pain
- ____ Hearing loss
- ____ Ringing in ears
- ____ Nasal drainage
- ____ Sinus pressure
- ____ Sore throat
- ____ Visual changes
- ____ Other: _____

_____

Respiratory
- ____ Cough
- ____ Known TB exposure
- ____ Shortness of breath
- ____ Wheezing
- ____ Other: _____

_____

Cardiovascular
- ____ Chest pain/discomfort
- ____ Claudication (pain in legs due to vascular disease)
- ____ Swelling (edema) in legs
- ____ Palpitations (fast heartbeat)
- ____ Other: _____

_____

Gastrointestinal
- ____ Abdominal pain
- ____ Blood in stools
- ____ Change in bowel habits
- ____ Constipation
- ____ Diarrhea
- ____ Heartburn/indigestion
- ____ Loss of appetite
- ____ Nausea
- ____ Vomiting
- ____ Other: _____

_____

Genitourinary
- ____ Painful urination
- ____ Blood in urine
- ____ Increased urination (Polyuria)
- ____ Urinary retention
- ____ Other: _____

_____

Women Only
- ____ Menstrual abnormalities
- ____ Post menopausal
- ____ Other: _____

_____

Skin/Dermatology
- ____ Skin infections - Please describe

_____

_____

_____
- ____ Itching
- ____ Rash
- ____ Other: _____

_____

Neurological
- ____ Dizziness
- ____ Extreme numbness
- ____ Weakness on one side of body
- ____ Gait problems
- ____ Headache
- ____ Memory loss/problems
- ____ Seizures
- ____ Other: _____

_____

Psychiatric
- ____ Anxiety
- ____ Depression
- ____ Other: _____

_____

Endocrine
- ____ Cold sensitivity
- ____ Heat sensitivity
- ____ Increased thirst
- ____ Increased hunger
- ____ Other: _____

_____

Musculoskeletal
- ____ Back pain
- ____ Painful joints
- ____ Swollen joints
- ____ Muscle weakness
- ____ Neck pain
- ____ Other: _____

_____

Hematology
- ____ Easy bleeding
- ____ Easy bruising
- ____ Swelling in lymph nodes
- ____ Other: _____

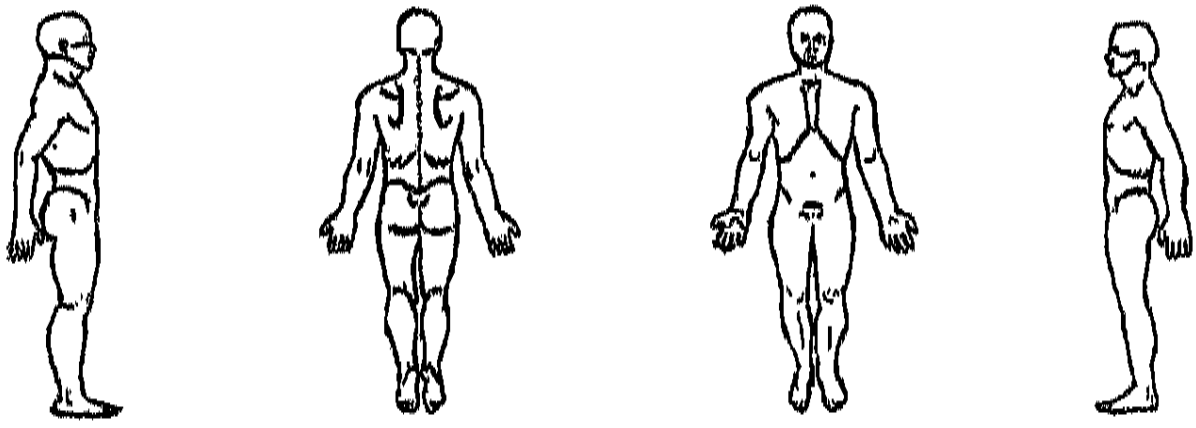
_____

Immune
- ____ Frequent infections
  Type:

_____
- ____ Food allergies
- ____ Seasonal allergies
- ____ Other: _____

_____

Color or mark the area on the diagram where you have pain.



When did this pain begin? _____

Can you trace your pain to an injury or event? Please describe: _____

_____

How long does it last? _____

Please describe your pain. ____ Ache ____ Burning ____ Deep ____ Dull ____ Sharp ____ Stabbing
____ Shooting ____ Throbbing ____ Localized to one area ____ Spread out over several areas

What treatments have you had for this current problem (such as physical therapy, epidural injections, TENS. unit, etc.)? Also, indicate the approximate date of the last treatment.

_____

_____

_____

Did they help? Circle: Yes No

Comment: _____

What in particular makes your pain worse?

_____

_____

What eases your pain? _____

Do you have any feeling of numbness or tingling? Circle: Yes No
Please indicate location on the diagram above.

PAST MEDICAL/SURGICAL HISTORY: Please circle any previous and ongoing illnesses such as (but not limited to):

Heart Disease	COPD/Emphysema	Anemia	Reflux/GERD
Heart Attack	Diabetes	Bleeding Problems	Seizure/Epilepsy
High Blood pressure	Kidney Problems	Stroke	Drug/Alcohol abuse
Cancer	Blood Clot	Stomach Ulcers	Migraines

If you have had other medical conditions not listed above, please list them below. Also, please list any procedures or surgeries you have had in the past. Please indicate the year.

Medical Condition/Procedure/Surgery Year

FAMILY HISTORY: Do any illnesses occur frequently in your family?

Illness Family member/Comments

SOCIAL

Do you use tobacco products? Circle: Yes No
If yes, what type? Cigarettes Cigars Dip/Chew Other: _____
How much? _____ For how many years? _____
Have you ever used tobacco products? Circle: Yes No
If yes, what type? _____ For how many years? _____
Do you use alcohol? Circle: Yes No
If yes, what type? Beer Wine Other: _____
How much? _____ For how many years? _____
Are you currently working? Circle: Yes No
Current occupation: _____ For how long? _____

Neurosurgery Arkansas

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QUESTIONS WE NEED ANSWERED IN CASE WE SCHEDULE ANY SCANS FOR YOU

ARE YOU CLAUSTROPHOBIC ? _____ YES _____ NO
ARE YOU A DIABETIC ? _____ YES _____ NO
ARE YOU ALLERGIC TO THE CONTRAST THAT MIGHT BE INJECTED DURING A SCAN ? _____ YES _____ NO
DO YOU HAVE HIGH BLOOD PRESSURE? _____ YES _____ NO
DO YOU HAVE KIDNEY FAILURE ? _____ YES _____ NO
DO YOU HAVE A FAMILY HISTORY OF KIDNEY DISEASE AND/OR KIDNEY FAILURE ? _____ YES _____ NO
ARE YOU ON KIDNEY DIALYSIS ? _____ YES _____ NO
YOUR AGE _____ YEARS OLD
YOUR WEIGHT _____ POUNDS
HAVE YOU HAD ANY BLOOD WORK DONE IN THE PAST 30 DAYS?
_____ YES _____ NO ..IF YES DOCTORS NAME THAT ORDERED THE BLOOD WORK / DR _____
HAVE YOU EVER MACHINE SHOP WELDED ? _____ YES _____ NO
HAVE YOU EVER HAD HEART SURGERY ? _____ YES _____ NO
HAVE YOU EVER HAD BRAIN SURGERY ? _____ YES _____ NO
HAVE YOU EVER HAD BACK SURGERY ? WHEN? _____ _____ YES _____ NO
DO YOU HAVE ANY METAL IN YOUR BODY ? _____ YES _____ NO
DO YOU HAVE A PACEMAKER ? _____ YES _____ NO
HAVE YOU HAD A LIVER TRANSPLANT ? _____ YES _____ NO
ARE YOU TAKEN IN FORMS OF BLOOD THINNERS? _____ YES _____ NO

DO YOU CURRENTLY USE ANY ILLEGAL SUBSTANCES? _____YES _____NO

NEUROSURGERY ARKANSAS

PRIVACY NOTICE ACKNOWLEDGMENT

The signature below acknowledges a copy of this Notice was RECEIVED (not necessarily read).

Date

Patient/Legal Representative Signature

State Capacity, if Legal Representative

AUTHORIZATION TO DISCLOSURE HEALTHCARE INFORMATION

Patient's Name:_____ DOB:_____ SS#:_____

Below is a list pf persons that you give permission for our clinic to discuss and use the patient's protected health information, including condition and treatment plan, test results, prescriptions, X-rays:

Name	Relationship to You	Telephone Number

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to receive or use this patient's healthcare information.

Date

Patient Signature/Legal Representative

If legal representative, explain the capacity:_____