Date:
Zip Code ____ Telephone Number ____ Date of Birth: ____

University Neurosurgery

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:	☐ M ☐ F	**AGE:**
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	**Occupation:**	
Referring doctor: Address:		Phone #

Primary care doctor: Address:

Phone #

PRESENT PROBLEM	
CHIEF COMPLAINT:	
How long have you had this problem?	
What caused the problem?	
What makes your symptoms worse?	
Do you have any weakness and if so where?	
Do you have any numbness and if so where?	
What other treatments have you had?	☐Physical therapy ☐ Injections
Is this a work related problem?	
Is there any lawsuit regarding the injury?	

WHO REFERRED YOU TO UNIVERSITY NEUROSURGEONS: ☐ DOCTOR ☐ FRIEND ____ ☐ INTERNET ☐ TV/RADIO

PAST MEDICAL HISTORY

Height: ____	Weight: ____

☐ Hypertension	☐ Liver disease
☐ Diabetes ☐Insulin dependent	☐ kidney disease
☐ Heart Disease	☐ Cancer Type?
List any medical problems that other doctors have diagnosed	

Past Surgical History

Year	Surgery	Hospital / Doctor

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Medications **(list your prescribed drugs)**

Name the Drug	Dose (mg)	Frequency Taken	More Medications
			☐Aspirin ☐Blood thinners

Allergies to medications

Name the Drug	Reaction You Had	Name the Drug	Reaction You Had

SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)		
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	How many drinks per week?		
	Are you concerned about the amount you drink?	☐ Yes	☐ No
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes – pks./day ☐ # of years ☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls (in the past 6 months)?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	

SYSTEMS REVIEW

☐ YES ☐ NO **Constitutional** Fever Weight loss/gain	☐ YES ☐ NO **Chest/Heart** Chest pain Palpitations	☐ YES ☐ NO **Neurological** Memory changes Difficulty walking Slurred speech Numbness
☐ YES ☐ NO **Head/Neck** Neck pain Headaches	☐ YES ☐ NO **Back** Lower back pain	☐ YES ☐ NO **Endocrine** Cold/heat intolerance Excessive thirst
☐ YES ☐ NO **Ears / Nose** Hearing loss Ringing Nose bleeding	☐ YES ☐ NO **Gastrointestinal** Nausea/vomiting Abdominal pain Rectal bleeding	☐ YES ☐ NO **Hematological** Easy bleeding or bruising Lymph node swelling
☐ YES ☐ NO **Eyes** Eye pain/burning Loss of vision Double Vision	☐ YES ☐ NO **Genitourinary** Urinary frequency Burning with urination Sexual function problems	☐ YES ☐ NO **Psychiatric** Depression Anxiety Psychosis
☐ YES ☐ NO **Throat** Sore throat	☐ YES ☐ NO **Skin** Rashes or lesions:	☐ YES ☐ NO **Lungs** Shortness of breath Cough

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No

Patient Signature ____________________ Physician Signature ____________________

University Neurosurgery
Patient Education and Self-Assessment

Patient Name: ______________________________ Date of Birth: ___________

The Doctor or Nurse will need to educate you about your condition and/or medication.

1. Please indicate if you believe any of the items listed below will interfere with your ability to learn about your medicine condition(s) or medication(s)

   - ☐ No difficulties
   - ☐ I cannot hear well enough to receive verbal information
   - ☐ I cannot see well enough to read printed information
   - ☐ I do not speak English well
   - ☐ I cannot read English well
   - ☐ I have trouble remembering things
   - ☐ Other, specify ______________________________________

2. Is there someone needed to interpret for you? ☐ Yes ☐ No

3. How do you prefer to learn: ☐ Written Instruction ☐ Oral Instruction ☐ Demonstrations

4. Are you experiencing pain or have you had pain in the past 6 months? ☐ Yes ☐ No

   If Yes, location:______________________ Rate 0-10 (0=no pain, 10=severe pain) ______

5. Do you have any dietary restrictions? ____

6. Can we leave messages regarding your tests results or other medical communication?

At your home	☐ Yes	☐ No	Telephone # ( ) _______ - ___________
At work	☐ Yes	☐ No	Telephone # ( ) _______ - ___________
On a cell phone	☐ Yes	☐ No	Telephone # ( ) _______ - ___________

____ ____________________

Patient's Signature/Person Completing Form Date

Office Use Only

____ ____________________

MD/Designate reviewed this form Date

☐ No limitations or barriers to learning ☐ See office notes for comments

University Neurosurgery

Patient Name: ______________________________ **Date of Birth:** _____________

For our records, please provide the following information

[ ] Please check here if you do no want reports sent to your physicians

Primary Care Physician Name:	
Street Address:	
City:	State Zip
Phone #	Fax #

Referring Physician Name:	
Street Address:	
City:	State Zip
Phone #	Fax #