WVU Medicine

Neurosurgery Clinic
Please complete this form and bring to your appointment.

**PATIENT NAME:**_____

**DOB:**_____

**General Medical Information:**

Are you allergic to any medications? ☐ no ☐ yes

If yes, please list: _____

_____

_____

List your medications & dosages: _____

_____

_____

Have you ever had any surgery? ☐ no ☐ yes

If yes, please list: _____

| **Have you ever had…** | No | Yes | |
|---|---|---|---|
| Hypertension (high blood pressure)? | ☐ | ☐ | |
| Diabetes? | ☐ | ☐ | |
| Asthma? | ☐ | ☐ | |
| Emphysema? | ☐ | ☐ | |
| TB (tuberculosis)? | ☐ | ☐ | If so, fully treated?_____ |
| Crohn's disease, Irritable Bowel, ulcerative colitis? | ☐ | ☐ | |
| Multiple Sclerosis (MS)? | ☐ | ☐ | |
| Polio? | ☐ | ☐ | What age?_____ What was affected? _____ |
| Seizures? | ☐ | ☐ | |
| Peptic ulcers? | ☐ | ☐ | |
| Heart attack (MI)? | ☐ | ☐ | When?_____ Stents? _____ Cardiac cath? _____ |
| Chest pain? | ☐ | ☐ | How often?_____ |
| Mitral valve prolapse? | ☐ | ☐ | |
| Hepatitis? | ☐ | ☐ | Type A B C Get treated? Yes No |
| Rheumatic fever? | ☐ | ☐ | |
| Stroke, TIA, paralysis? | ☐ | ☐ | |
| Cancer? | ☐ | ☐ | What type?_____ |
| Eye problems? | ☐ | ☐ | Glaucoma_____ Macular Degeneration_____ |
| Pancreatic problems? | ☐ | ☐ | Pancreatitis_____ Pancreatic failure _____ |
| Kidney stones? | ☐ | ☐ | How often?_____ Prior Lithotripsy? _____ |
| High cholesterol or lipids? | ☐ | ☐ | |
| Do you smoke? | ☐ | ☐ | Cigarettes ____ packs/day Cigar Vape |
| Smokeless tobacco? | ☐ | ☐ | Dip Chew Snuff |
| Do you drink alcohol? | ☐ | ☐ | Amount/week_____ |

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Legally separated ☐ Widowed

**Any Children:** ☐ No ☐ Yes How many? 1 2 3 4 5 6 7 other

What is/was your job or occupation? _____ Still working?___ Retired? ___

**What was your highest level of education?**

_____ Some High School (last grade? _____)
_____ GED
_____ High School graduate
_____ Technical School/College
_____ Some College (# years?____)
_____ College 4 or more years
_____ Graduate/professional school
_____ Post graduate

**Is your mother still alive?** ☐ No ☐ Yes If not, what was her age at death?____ Cause of death _____

**Is your father still alive?** ☐ No ☐ Yes If not, what was his age at death?____ Cause of death _____

**Circle any condition your close relatives may have had:**

Stroke MI (heart attack) Diabetes Kidney Failure Brain tumor Lung Cancer
High Blood Pressure Deafness Blindness High Cholesterol Seizures Colon Cancer

| **Review of Systems** | No | Yes | |
|---|---|---|---|
| Do you have false teeth, dentures or plates? | ☐ | ☐ | |
| Do you wear corrective lenses? | ☐ | ☐ | Glasses _____ Reading Glasses only_____ Contact lens_____ |
| Do you ever have vertigo (feel like the room is spinning)? | ☐ | ☐ | |
| Do you have dizzy spells? | ☐ | ☐ | |
| Do you ever pass out or black out? | ☐ | ☐ | If so, how often?_____ When was the last time?_____ |
| Do you have problems swallowing? | ☐ | ☐ | If so, have you seen a GI or ENT doctor for this? Yes_____ No_____ |
| Do you have frequent heartburn/indigestion/reflux? | ☐ | ☐ | |
| Do you have a hiatal hernia? | ☐ | ☐ | |
| Do you ever vomit blood? | ☐ | ☐ | |
| Do you ever cough up blood? | ☐ | ☐ | |
| Do you have a recurring or persistent cough? | ☐ | ☐ | |
| Do you have bright red blood in your stool? | ☐ | ☐ | |
| Are your stools frequently dark black? | ☐ | ☐ | |
| Do you get short of breath? | ☐ | ☐ | Is it associated with chest pain? _____ |
| Do you have night sweats? | ☐ | ☐ | |
| Have you had jaundice or other liver problems? | ☐ | ☐ | |
| Have you ever had gout? | ☐ | ☐ | |
| Have you ever been diagnosed with fibromyalgia? | ☐ | ☐ | |
| Have you ever received blood products? | ☐ | ☐ | |
| Do you bruise easily or have a history of bleeding easily? | ☐ | ☐ | If so, does anyone in your family have hemophilia? _____ |
| Have you ever had a blood clot in your legs or lungs (pulmonary embolus)? | ☐ | ☐ | |
| Do you have sleep apnea? | ☐ | ☐ | If yes, do you use a CPAP machine? Yes_____ No_____ |
| Have you lost or gained more than 10 pounds in the past 3 months? | ☐ | ☐ | |
| **Men:** Have you ever had prostate problems? | ☐ | ☐ | Cancer Difficulty urinating Elevated PSA |
| **Women:** Could you possibly be pregnant? | ☐ | ☐ | |
| **Women:** Have you ever had a mammogram? | ☐ | ☐ | Normal? Yes_____ No _____ |