UF Department of Neurosurgery

Patient Health History QUESTIONNAIRE

The information below is extremely important.
Please fill out this form on *as complete as possible*
Be sure to bring it with you to your clinic appointment

Patient Name: _____ Date: ____/____/_____

Shands Medical Record Number:_____ **DOB** ___/___/____ **Age**: ____

Contact phone: ____-____-_____ Family contact name: _____ Phone: ____-___-_____

Please list all of the operations you have had: **Date:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Attach extra page if necessary.

Please list all medical problems you have had:

High blood pressure Heart disease Diabetes Bleeding disorder

Cancer

Other(s) _____

Are you allergic to any medicines, X-ray dye, or iodine? Yes No
I AM ALLERGIC TO: **TYPE OF REACTION:**

List all medications you take routinely, along with the doses: (Use additional page if needed)

Medication	Dose	Frequency

Are you taking any "blood thinning" medications?: Yes - Please indicate below No

Aspirin or aspirin containing medication Anti-inflammatory medication Plavix

Coumadin Fish Oil Other_____

Do any of the following diseases run in your family? Yes- Indicate below No

Heart disease . High blood pressure Cancer –Type _____

Diabetes Brain or spinal cord tumors Others _____

Marital Status?

Single . Married Please list your hobbies:
Divorced Widowed _____

What is your occupation? _____

Are you: Right handed Left handed

Do you smoke cigarettes? Yes No
If **Yes**, how many cigarettes per day? _____ How many packs per day? _____

Have you ever smoked cigarettes? Yes No If Yes, when did you stop? _____

Do you drink alcohol? Yes No If **Yes**, how much daily? _____

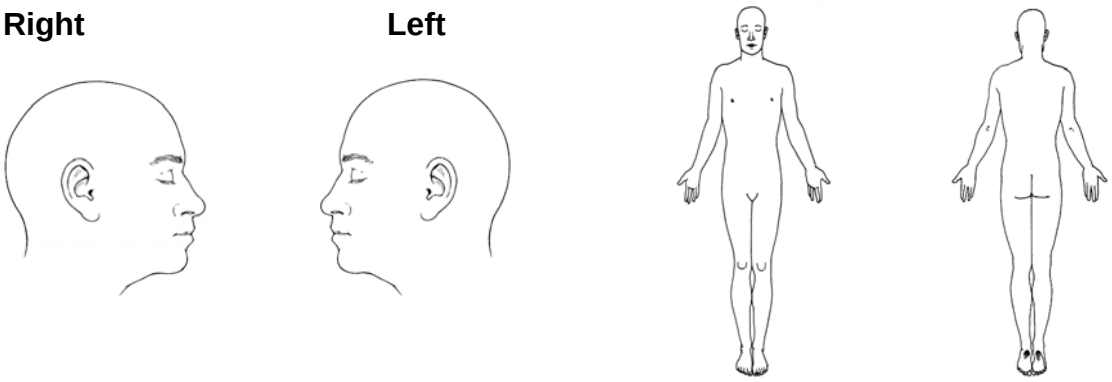
Do you use "recreational" drugs? Yes No

Are you at risk for AIDS (e.g.. sexual orientation, drug abuse, previous blood transfusion)?
No Yes, please explain:_____

Are you, or could you be pregnant? Yes No Date of last menstrual period? _____

On the diagram below indicate where your pain is usually located. Please shade the painful areas.

Right **Left**



On the scale of 1 to 10 below, with 10 being the worst pain you can imagine and 1 being essentially no pain, please rate the typical or average amount of pain you have during the day. Circle a number.

1 2 3 4 5 6 7 8 9 10

Review of Systems

Do you currently, or have you had, a problem with:

Genitourinary	***Circle One***	
Urinary tract infections	Yes	No
Painful urination	Yes	No
Blood in your urine	Yes	No
Difficult starting/stopping stream	Yes	No
Incontinence	Yes	No
Kidney stones	Yes	No
Prostate cancer (male)	Yes	No
Uterine or cervical cancer (female)	Yes	No

Musculoskeletal		
Broken bones	Yes	No
Arm or leg weakness	Yes	No
Arm or leg pain	Yes	No
Joint pain or swelling	Yes	No
Arthritis	Yes	No

Integumentary		
Skin disease	Yes	No
Skin cancer	Yes	No
Breast pain, tenderness (female)	Yes	No
Nipple discharge (female)	Yes	No

Neurological	***Circle One***	
Fainting spells or “black outs”	Yes	No
Seizures	Yes	No
Problems with memory	Yes	No
Disorientation	Yes	No
Difficulty with speech	Yes	No
Inability to concentrate	Yes	No
Double or blurred vision	Yes	No
Weakness in arms and/or legs	Yes	No
Loss of sensation	Yes	No
Difficulty with balance	Yes	No

Psychiatric

Anxiety	Yes	No
Depression	Yes	No

Other psychiatric disorder and/or treatment: _____

_____

_____

Hematologic/Lymphatic

Anemia	Yes	No
Hemophilia	Yes	No
Bleeding tendencies	Yes	No
Blood transfusion	Yes	No
Persistent swollen glands or lymph nodes	Yes	No

Allergic/Immunologic

Food allergies	Yes	No
Inhalant (nasal) allergies	Yes	No
Autoimmune disease (lupus, rheumatoid arthritis, etc.)	Yes	No

Constitutional:

Fever	Yes	No
Weight Loss	Yes	No
Excessive Fatigue	Yes	No

Eyes:

Wear glasses	Yes	No
Infections	Yes	No
Injuries	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No

Ear, Nose, Throat & Mouth	***Circle One***	
Wear hearing aid (s)	Yes	No
Hearing loss	Yes	No
Ear pain	Yes	No
Ear infections	Yes	No
Ringing in ears	Yes	No
If yes, circle one: Left Right Both		
Nose bleeds	Yes	No
Nasal congestion	Yes	No
Nasal drainage	Yes	No
Inability to smell	Yes	No
Sinus problems	Yes	No
Balance disturbance (vertigo, spinning, etc.)	Yes	No

Cardiovascular		
Chest pain or angina	Yes	No
High blood pressure	Yes	No
Irregular pulse	Yes	No
Heart murmur	Yes	No
High cholesterol	Yes	No
Swelling in hands or feet	Yes	No
Leg pain while walking	Yes	No

Respiratory		
Asthma	Yes	No
Emphysema	Yes	No
Shortness of breath	Yes	No
Pneumonia	Yes	No
Lung cancer	Yes	No
Bloody sputum	Yes	No

Gastrointestinal		
Nausea	Yes	No
Vomiting	Yes	No
Blood in your vomit	Yes	No
Liver disease	Yes	No
Jaundice	Yes	No
Abdominal pain	Yes	No
Change in bowel habits	Yes	No
Ulcers or Gastritis	Yes	No
Colon cancer	Yes	No

Endocrine		
Diabetes	Yes	No
Thyroid disease	Yes	No
Excessive thirst/urination	Yes	No

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The information below is extremely important.
Be sure to bring it with you to your clinic appointment
In preparation for your scheduled appointment, please be sure:

- ! You have completed and signed this form
- ! You have all pertinent medical records
- ! If you have a cardiac history, bring results of your last EKG and/or other tests.
- ! You have your actual x-ray films, not just reports
- ! You have your insurance card

Do not hesitate to call our office at 352-273-9000 if you have questions or need assistance in completing this form.
Department of Neurosurgery
University of Florida

The information on this form is accurate to the best of my knowledge:

_____ ___/____/____
Patient signature Date completed

I have reviewed the above information with the patient:

_____ ____/____/____
Physician signature Date reviewed

_____ ____/____/____
Physician signature Date reviewed

_____ ____/____/____
Physician signature Date reviewed