



Associates in Neurosurgery

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Phillip G. St. Louis, M.D. Health History

Date: _____

Name: *Last* _____ *First* _____ *MI* _____

DOB: _____ Age _____ Gender: Male Female Transgender

Height: _____ Weight: _____ Left Handed Right Handed

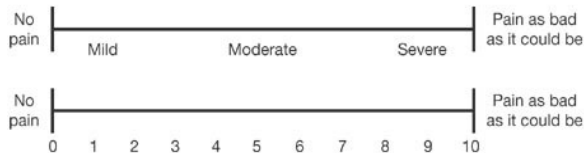
Employer: _____ Occupation: _____

Referring Physician
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: (____) _____
Fax Number: (____) _____

Primary Care Physician
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: (____) _____
Fax Number: (____) _____

Chief Complaint-(The main reason for your visit)

- Pain--Location: _____
- Numbness --Location: _____
- Weakness --Location: _____
- Other: _____



Describe the quality of the symptom: Sharp Dull Burning Aching
 Other: _____

Describe the intensity of the symptom: Mild Moderate Severe
 Other: _____

Describe the frequency of your symptom: Constant Intermittent Daily
 Other: _____

What makes it better? _____

What makes it worse? _____

How long have you had this problem? _____

Your problem is the result of: Automobile Incident Work Incident Unknown
Since the start of your problem, it has gotten: Worse Better Stayed the Same
Have you ever had similar symptoms prior to above: No Yes
If yes, when: _____

Which of the following, if any, have been done within the last year? MRI CT Myelogram
 EMG/NCT Nerve Blocks Angiogram Physical Therapy
 Other _____

Which of the above, if any, provided relief? _____

Litigation pending: Yes No
Employment Status: Full-time Part-time Not Employed Retired
Work Status: Regular Duty Light Duty
Work Restrictions: _____

Have you been to work since the symptoms started? Yes No Off & On

Medical Problems: COPD/Lung Diabetes Heart Disease/Attack High Blood Pressure
 Kidney Stroke Thyroid Cancer _____ Other _____

Patient Name: _____

Date: _____

ALL Surgeries	Year	Complications

Have you ever had problems with anesthesia? Yes No If yes, explain. _____

Medications (Prescription & Over the Counter)	Dosage (Mg)	Frequency (# time/day)	Reason Condition Treated	Prescribing Doctor

Do you take aspirin or any aspirin products? _____ If yes, How much and how often? _____

Do you take any blood thinners (e.g. Plavix, Coumadin (Warfarin) Heparin, Lovenox, etc.)? _____

KNOWN ALLERGIES:

Family Member	Alive	Deceased	Age	Medical History/Cause of Death
Grandmother (Mom's)	A	D		
Grandfather (Mom's)	A	D		
Grandmother (Dad's)	A	D		
Grandfather (Dad's)	A	D		
Father	A	D		
Mother	A	D		
Sibling <input type="checkbox"/> M <input type="checkbox"/> F	A	D		
Sibling <input type="checkbox"/> M <input type="checkbox"/> F	A	D		

SOCIAL HISTORY

Marital Status: Single Married Partner Divorced Widowed Separated

Are you pregnant? _____ Breastfeeding _____ Do you live alone? _____ Who lives with you? _____

Do you have children? _____ How many boys? _____ How many girls? _____

Do you travel? _____ How often in a year? _____

Tobacco Use Never Quit Date _____ Current Are you interested in quitting? Yes No

Cigarettes: packs/day _____ # of years _____

Pipe: /day _____ # of years _____ Cigar: /day _____ # of years _____

Snuff/day _____ # of years _____ Chew/day _____ # of years _____

Do you drink alcohol? No Yes # drinks/week _____ Is your alcohol use a concern for you or others? No Yes

Do you use recreational drugs? No Yes Have you ever used needles to inject drugs? No Yes

Are you at risk for Immune Deficiency (e.g. HIV/AIDS sexual orientation/behavior, drug abuse, previous blood transfusion, chemo?) No Yes, Please Explain: _____

Caffeine Intake: None Coffee/tea/soda: _____ cups/day

Are you satisfied with your weight: Yes No How do you rate your diet? Good Fair Poor

Do you eat or drink four servings of dairy or soy daily or take calcium supplements? Yes No

Do you exercise regularly? Yes No

What kind of exercise? _____

How long (minutes) _____ How often? _____

If you do not exercise, why? _____

REVIEW OF SYSTEMS

Patient Name: _____

Date: _____

Please indicate (by check mark) below which, if any, medical history you have experienced within the last 6 months.

- Constitutional
- Fever
 - Weight loss
 - Excessive fatigue
 - Chills/night sweats

- Eyes
- Wear Glasses
 - Date of Last Exam: _____
 - Glaucoma/Partial Vision Loss
 - Cataracts
 - Painful Vision

- Ear, Nose, Throat and Mouth
- Hearing loss
 - Ear infection
 - Ringing in ears
 - Circle one: Left Right Both
 - Balance disturbance (vertigo, spinning, etc)
 - Nosebleeds
 - Nasal congestion
 - Nasal drainage
 - Amount _____ Color _____
 - Inability to smell
 - Sinus problems
 - Sinus headaches
 - Sore throats
 - Mouth sores

- Cardiovascular
- Chest pain or angina
 - High blood pressure
 - Irregular pulse
 - Heart murmur
 - High cholesterol
 - Swelling in feet or hands
 - Leg pain while walking

- Respiratory
- Asthma
 - Chronic cough
 - Emphysema
 - Shortness of breath
 - Bronchitis
 - Pneumonia
 - Lung cancer
 - Bloody sputum

- Gastrointestinal
- Indigestion of pain with eating
 - Nausea
 - Vomiting
 - Blood in your vomit
 - Liver disease
 - Jaundice
 - Abdominal pain
 - Change in your bowel habits
 - Ulcers or gastritis
 - Colon cancer

- Genitourinary
- Urinary tract infections
 - Painful urination
 - Blood in your urine
 - Difficulty starting and stopping urination
 - Stream
 - Incontinence
 - Kidney stones
 - Prostate cancer (males)
 - Endometriosis (females)
 - Uterine or cervical cancer (females)

- Musculoskeletal
- Neck pain
 - Arm or leg weakness
 - Back pain
 - Arm or leg pain
 - Joint pain or swelling
 - Arthritis
 - Muscle pain or tenderness in joints

- Integumentary
- Skin diseases
 - Skin cancer
 - Breast pain, tenderness or swelling
 - Nipple discharge (females)

- Neurological
- Fainting spells or blacking out
 - Seizures- Date of last one _____
 - Problems with memory
 - Disorientation
 - Difficulty with speech
 - Inability to concentrate
 - Double or blurred vision
 - Face weakness
 - Coordinator in arms and/or legs
 - Headaches
 - Stroke

- Psychiatric
- Anxiety
 - Depression
 - Other Psychiatric Disorder _____

- Endocrine
- Diabetes
 - Thyroid disease
 - Increase appetite
 - Excessive thirst or urination
 - Hormone problems

- Hematology/ Lymphatic
- Anemia
 - Hemophilia
 - Bleeding tendencies
 - Persistent swollen glands or lymph nodes
 - Blood transfusion

- Allergic/Immunologic
- Food allergies
 - Inhalant allergies (nasal)
 - Immunology disorders