METROPOLITAN NEUROSURGERY, PA
PATIENT HEALTH HISTORY FORM

Today's Date: _____

PLEASE ANSWER ALL QUESTIONS:.

Patient Name: _____ Birth Date: _____ Weight: _____

Requesting Physician: _____ Family Doctor/Clinic: _____

Why are you seeing the doctor today? _____

Was this condition related to a WORK injury? YES NO

If yes, what date did the injury occur? _____

Was this condition related to an AUTO accident? YES NO

If yes, what was the date of the accident? _____

Was this related to any OTHER type of injury? YES NO What was the date of injury? _____

Describe the injury. _____

Have you been treated elsewhere for this condition? Yes NO

If yes, where? _____

Past Medical History:

List all previous hospitalizations or surgeries:

_____ Date: _____

_____ Date: _____

_____ Date: _____

List all Medical problems and Conditions that you have had or currently have:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Medications:

List any medications you are currently taking:

Name:	Dosage (Milligrams)	Frequency (# times per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INCLUDING OTC MEDICATION SUCH AS ASPIRIN OR VITAMIN E

Allergies:

Are you allergic to any medications? If yes list:

_____

Type of reaction: ____Rash _____Hives _____Severe Reaction _____ Intolerance ____ anaphlaxis ____ Other_____

ARE YOU ALLERGIC TO LATEX? _____

Health Habits:

Do you use tobacco in any form? YES NO If yes, how much? _____

Do you drink alcohol? YES NO If yes, how much? _____

Have you ever used IV drugs? YES NO

Do you use herbs, vitamins or nutritional supplements? YES NO

If yes, please list: _____

PLEASE CIRCLE IF YOU HAVE A: DEFIBRILLATOR OR PACEMAKER

Family History:

Do you have a family history of arthritis or disease of the muscles, bones or nervous system? YES NO
If yes, please describe: _____

Do you have a family history of cancer? YES NO
If yes, please describe: _____

Do you have a family history of bleeding/clotting problems? YES NO
If yes, please describe: _____

Do you have a family history of any other diseases you would like your doctor to know about? YES NO
If yes, please describe: _____

Employment/Social History:

Are you currently employed? YES NO If yes, what is your occupation? _____
How long? _____ Employer: _____
Is your work ___Heavy ____ Medium ____ Light ____ Sedentary
Do you have any current work restrictions? YES NO
If yes, please describe: _____
What is your marital status? ___Single ____ Married ____ Widowed ____ Divorced or Separated
Who lives with you? _____ Pets? _____

Review of Systems:

Do you currently have any problems in the following areas? If yes, please provide additional information.

	YES	NO	Details
GENERAL (fever, heat stroke, wt loss/wt gain, fatigue, difficulty sleeping)			
EARS, NOSE, THROAT (hearing, sinus, earache, cough, dry mouth)			
EYES (vision problems, blind spots, glaucoma, eye pain)			
CARDIOVASCULAR (High BP, racing pulse, blood clots)			
RESPIRATORY (congestion, wheezing, shortness of breath, COPD)			
URINARY, KIDNEY, BLADDER (painful urination, frequency, incontinence, ect)			
MUSCLE, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, gout, etc)			
DIGESTIVE (heart burn, nausea, indigestion, abdominal pain, bloating)			
SKIN (rashes, growths, warts, etc)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, thyroid, etc)			
BLOOD/LYMPH (bleeding, enlarged lymph nodes, problems with blood transfusions)			
ALLERGIC/IMMUNE (sneezing, swelling, redness, itching, hives, lupus, etc)			

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____