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:
Have you ever used tobacco YES NO If yes, how much? ____________________ Type: __________________
If no longer use tobacco Stop Date ___________________
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?
(circle one) Single Married Widowed Divorced 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)			
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, blood transfusions)			
ALLERGIC/IMMUNE (sneezing, swelling, redness, itching, hives, lupus, etc)			

Patient Signature: ____ Date: ________________

Physician Signature: ____ Date: ________________