OVERLAKE MEDICAL CLINICS NEUROSURGERY

New Patient Intake Form

Please fill this out entirely and bring it with you to your first office visit.

This form is meant to gather as much information as possible. Please fill it out to the best of your knowledge. If there are areas you can not or would not like to answer, please leave that area blank.

Contact Information

Full Name _____*Date* _____

Date of Birth _____ *Age* _____ *Gender Male / Female*

*Name of Primary Care Physician*_____

*How or by whom were you referred to this clinic?*_____

General Information

Height _____*Weight* _____*Weight 1 yr ago* _____*Maximum weight* _____*When* _____
*(To be filled out by Medical Assistant): BP*_____ *HR*_____ *O2*_____ *Temp*_____
Females only: Are you currently pregnant or suspect you may be pregnant? Yes / No
Do you have any metallic implants? (Circle One) ***YES NO***
What is the reason for your visit? _____
What diagnostic studies have you done (circle all that apply and list dates):
*MRI*_____ *CT*_____ *EMG*_____ *Xrays*_____*CT Myelogram*_____

Do you have pain? Y/N Where is your pain? _____ *How severe is your pain?*_____ *(0-10)*

What type of pain do you have? (circle all that apply) Stabbing/Throbbing/Dull Ache/Pulsating/Tingling/Numbness

Please list, by name, all current prescription medications, over-the-counter medications, and all vitamins/supplements/herbs, including dose that you take regularly at this time.

Name	Dose	Frequency	When did you start?

Do *you have any drug, food or chemical allergies? If so, please list them below:*

Allergy	*Reaction*

No known drug allergies

Past Medical History

Please check any medical conditions you have been diagnosed with.

Alzheimer's Disease
Aneurysm
Aortic Valve Disorder
Arachnoid Cyst
Arnold Chiari Syndrome
Arteriovenous Malformation, Brain
Asthma/Breathing Problems
Brain Hemorrhage
Cancer _____ (specify)
Coagulation/Clotting Disorder
COPD/Emphysema
Degeneration, Lumbar Disk
Diabetes Type _____ Controlled? Y N
Disc Disorder, Cervical
Emphysema/COPD
Epilepsy
Fracture, Lumbar
Fracture, Thoracic
GI ulcer
GI bleeding
Heart Attack
Heart Murmur
Hepatitis A B or C (please circle)
Hypercholesterolemia (High Cholesterol)
Hypertension (High Blood Pressure)
Hypothyroidism
Kyphosis/Scoliosis
Mitral Valve Disorder
Multiple Sclerosis
Neck Pain (Cervicalgia)
Neuropathy
Pain, Low Back (Lumbago)
Parkinson's Disease
Pituitary Tumor
Polycystic Kidney Disease
Rheumatoid Arthritis
Seizures
Spondylolisthesis (spine instability)
Stroke
Trigeminal Neuralgia
Other _____

Past Surgical History

Please check any surgical procedures you have had and list the date when you had them in the blank.

Appendix _____
Breast Biopsy/Mastectomy _____
Colon_____
Gallbladder _____
Heart, Angio/Stent _____
Heart, Bypass _____
Heart, Valve _____
Hernia _____
Hip Replacement _____
Knee Surgery/Replacement _____
Spine Surgery _____ (specify) _____
Thyroid Surgery_____
Vascular Surgery_____
Other _____ _____

Family History

NONE
Epilepsy
Heart disease
Hypertension
Diabetes
Tumor/Cancer (List types):
Stroke
Aneurysm
Other:

Social History

Alcohol Drinks/Week _____
Tobacco Packs/Day _____
With whom do you reside? _____
Working Occupation: _____
Retired When? _____
Unemployed since when? _____
Circle one: Married/Single/Divorced/Widowed
Work related injury When did it occur? _____

Review of Systems

CONSTITUTIONAL ☐*neg*	***EYES*** ☐*neg*	***EAR, NOSE, THROAT*** ☐*neg*	***CARDIORESPIRATORY*** ☐*neg*	***GASTROINTESTINAL*** ☐*neg*
☐*Chills*	☐*Blindness*	☐*Dizziness*	☐*Shortness of breath*	☐*Nausea*
☐*Fever*	☐*Decreased acuity*	☐*Vertigo*	☐*Cough*	☐*Vomiting*
☐*Night sweats*	☐*Blurred vision*	☐*Ringing in ears*	☐*Bloody sputum*	☐*Diarrhea*
☐*Insomnia*	☐*Double vision*	☐*Decreased hearing*	☐*Wheezing*	☐*Bloody stool*
☐*Appetite change*	☐*Eye pain*	☐*Hoarseness*	☐*Chest tightness*	☐*Constipation*
	☐*Tearing*	☐*Sinus problems*	☐*Chest pain*	☐*Abdominal pain*
	☐*Dry eyes*	☐*Nose bleeds*	☐*Palpitations*	
	☐*Redness*	☐*Oral lesions*	☐*Rapid heart rate*	

GENITOURINARY ☐*neg*	***SKIN*** ☐*neg*	***NEUROLOGIC*** ☐*neg*	***MUSCULOSKELETAL*** ☐*neg*	***PSYCHIATRIC*** ☐*neg*
☐*Incontinence*	☐*Rashes*	☐*Numbness/tingling*	☐*Joint pain*	☐*Depression*
☐*Burning urination*	☐*Easy bruising*	☐*Memory problems*	☐*Muscle ache*	☐*Anxiety*
☐*Foul odor*	☐*Sores/lesions*	☐*Headaches*	☐*Difficulty walking*	☐*Moodiness*
☐*Urinary frequency*	☐*Edema*	☐*Tremors*	☐*Leg cramping*	☐*Irritability*
☐*Blood in urine*				

ENDOCRINE ☐*neg*		***HEME/LYMPHATIC*** ☐*neg*	***ALLERGIC/IMMUNE*** ☐*neg*	
☐*Menopause*		☐*Easy Bleeding*	☐*Infection*	
☐*Altered menses*		☐*Swollen nodes*	☐*Hives*	
☐*Nipple discharge*		☐*Easy Bruising*	☐*Anaphylaxis*	
☐*Weight change*		☐*Hepatitis*		
☐*Temperature intolerance*				

Recent Treatment

What non-surgical therapies have you undergone? Rate how effective each treatment was on a scale from 1-10.Please check all that apply.

Physical therapy *(1-10)*_____
Bracing *(1-10)*_____
Heating Pad *(1-10)*_____
Bed Rest *(1-10)*_____
Chiropractor *(1-10)*_____
TENS Stimulation *(1-10)*_____
Acupuncture *(1-10)*_____
Oral Steroids *(1-10)*_____
NSAIDS *(1-10)*_____

Epidural Steroid Injection
How Many: ____ What level/side: _____
Results: (1-10)_____
Selective Nerve Root Block
How Many: ____ What level/side: _____
Results: (1-10)_____
Radiofrequency Ablation
How Many: ____ What level/side: _____
Results: (1-10)_____