ROOM #:_____

NEW BRAIN PATIENT

CarePoint NEUROSURGERY

Date Seen: _____ **Blood Pressure:**_____ **Pulse:** _____

Weight: _____ **Height:**_____ **O_2 Sats:** _____

For office use only above this line.

Patient Name:_____ **Date of Birth:** _____ **Age:** _____

Referring Physician:_____ **Insurance Carrier:**_____

Present Complaint or Problem:

How long (days, weeks, or years) has this complaint/problem been going on? _____

Most recent images for the problem
you are being seen for today..... ☐ MRI ☐ CT ☐ X-Rays ☐ None ☐ Other: _____

Where were these images done? .... ☐ Health Images ☐ Invision ☐ Resiliance ☐ Touchstone ☐ Other: _____

When were these images done? _____

Diagnostic Testing..... ☐ EEG ☐ Other _____

Done by Dr:_____ **Date:**_____

Current symptoms, i.e., headaches, vision problems:

What activity or action make your symptoms worse?

What activity or action makes your symptoms better?

Treatments tried for this problem and when?

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY USING (PLEASE PRINT NEATLY) If none, please place ✓ in box: ☐

Name and dose (i.e., 2 mg, 60 mg, etc)	How often (i.e., one tab daily, one tab twice daily, two at bedtime)

Patient Name: _____

PAST MEDICAL HISTORY: Please ✓ in box next to any condition with which YOU have been diagnosed, or list other:

General Medical		Neurologic	Pertinent to Surgery
☐ Unremarkable / No medical problems	☐ Heart Disease	☐ Aneurysm	☐ Anticoagulation Therapy
☐ Anemia	☐ Hepatitis type: _____	☐ CVA/Stroke	☐ Bleeding Disorder
☐ Asthma	☐ HIV	☐ Brain Tumor	☐ Chronic Pain
☐ Atrial Fibrillation	☐ High cholesterol / lipids	☐ Hydrocephalus	☐ Clotting Disorder
☐ Autoimmune Disorder	☐ Hypertension / High Blood Pressure	☐ Migraines	☐ DVT
☐ BPH (prostate enlargement)	☐ Myocardial infarction / Heart Attack	☐ Multiple Sclerosis	☐ Hemophilia
☐ Cancer – type: _____	☐ Osteoarthritis	☐ Parkinson's Disease	☐ Narcotic use > 6 months
☐ COPD	☐ Osteoporosis	☐ Peripheral Neuropathy	☐ Problems w/ Anesthesia
☐ Depression	☐ Renal Disease	☐ Pituitary Tumor	☐ Pulmonary Embolism
☐ Diabetes	☐ Rheumatoid Arthritis	☐ Seizure Disorder	☐ Other: _____
☐ Fibromyalgia	☐ Sleep Apnea	☐ Spinal Cord Injury	
☐ GERD / Reflux	☐ Thyroid Disease: hypo or hyper	☐ TIA	
☐ Gout		☐ Traumatic Brain Injury	
		☐ Trigeminal Neuralgia	

Have you ever been *DIAGNOSED* by a physician with any other major health problem not listed above? ☐ No ☐ Yes

If yes, please list the diagnosis:

ALLERGIES: Are you allergic to *ANY* medication, food, or non-medications (such as pollen, etc.)? ☐ No ☐ Yes

If yes, please list below.

Name of Medication / Food / Agent you are allergic to	Type of Reaction (i.e. rash, breathing problems, swelling, etc.)

SURGICAL HISTORY: If you have had any surgery in the past, please list below:

Patient Name:_____

FAMILY HISTORY: Please ✓ in box next to any condition in which a member of your immediate family only (i.e., mother, father, brother, sister) has been diagnosed: If unknown/adopted/none, please ✓ in appropriate box: ☐ Unknown ☐ Adopted ☐ None

☐ FH Alcoholism	☐ FH Cervical, Ovarian, or Uterine Cancer	☐ FH High Cholesterol	☐ FH Other Cancer
☐ FH Anemia	☐ FH Colon Cancer	☐ FH Kidney Disease	☐ FH Psychiatric Care
☐ FH Arthritis	☐ FH Depression	☐ FH Liver Disease	☐ FH Respiratory Disease
☐ FH Blood Clots	☐ FH Diabetes	☐ FH Lung Cancer	☐ FH Seizures
☐ FH Bowel Disease	☐ FH Heart Disease	☐ FH Melanoma/Skin Cancer	☐ FH Stroke
☐ FH Breast Cancer	☐ FH Hypertension/High BP	☐ FH Osteoporosis	☐ FH Thyroid Disease

SOCIAL HISTORY

Do you currently use tobacco in any form?..... ☐ No ☐ Yes

If yes, do you smoke or chew tobacco? ..... ☐ Smoke ☐ Chew Number of packs per day: _____

If no, do you have a history of chewing/tobacco use? ☐ No ☐ Yes If yes, when did you quit?_____

Marital status: ..... ☐ Married ☐ Partner ☐ Single ☐ Divorced ☐ Widowed

Work status:..... ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Self-employed

What is or was your occupation? _____

Do you currently drink alcohol? ..... ☐ No ☐ Yes If yes, how much per week? _____

Do you currently use any recreational substances?.... ☐ No ☐ Yes If yes, what type and how often?_____

REVIEW OF SYSTEMS: Please ✓ in box next to any symptom in which you are currently experiencing:

General			
☐ Recent weight loss: # lbs _____	☐ Ringing in ears	☐ Nausea	☐ Rashes
☐ Recent weight gain: # lbs _____	☐ Chest pain	☐ Frequent indigestion	☐ Recent change in wart / mole
☐ Fever	☐ Palpitations	☐ Black, tarry or bloody stools	☐ Easy bleeding or bruising
☐ Night sweats	☐ Shortness of breath	☐ Difficulty urinating	☐ Depression
☐ Fatigue	☐ Swelling of feet or ankles	☐ Incontinence	☐ Anxiety
☐ Blurred vision	☐ Fainting	☐ Burning with urination	☐ Difficulty falling asleep
☐ Double vision	☐ Frequent cough	☐ Excessive thirst	☐ Early morning awakenings
☐ Blindness	☐ Difficulty breathing	☐ Unusual appetite	☐ Persistent feeling sad or blue
☐ Hearing loss	☐ Coughing up blood	☐ Frequent urination	☐ Loss of ability to enjoy life

Musculoskeletal		
☐ Back pain	☐ Joint swelling	☐ Shooting left arm pain
☐ Joint pain	☐ Leg cramps	☐ Shooting right leg pain
☐ Joint stiffness	☐ Shooting right arm pain	☐ Shooting left leg pain

Neurological		
☐ Fatigue	☐ Gait abnormality	☐ Seizure
☐ Weight loss	☐ Headache	☐ Tingling
☐ Balance difficulty	☐ Loss of sensation in a specific body area: _____	☐ Tremors
☐ Dizziness	☐ Loss of strength in a specific body area: _____	☐ Trouble with balance
☐ Fainting spells	☐ Numbness	☐ Trouble with coordination
☐ Falls	☐ Memory problems	

This Information is true and complete to the best of my knowledge:

Signature of Patient or Legal Guardian *Date*