Date: _____ Chart: _____

Neurosurgical Associates of Southwestern CT

BRAIN & SPINE SPECIALISTS

Neurosurgery - New Patient History Questionnaire

Welcome to Neurosurgical Associates of Southwestern CT! We ask that you take some time to complete this questionnaire to the best of your knowledge. **Please complete this form before your visit, and bring it with you the day of your appointment.** Also bring your insurance card, driver's license or identification card, Imaging (MRI/CT Scan/X-ray) CD's and reports, reports of previous neurological and neurosurgical testing consultations, and reports of significant medical problems.

Full Name: _____ DOB: _____ SS#: _____

Address: _____

Phone Numbers: (H): _____ (W): _____ (C): _____

Email: _____

Insurance Carrier: _____ ID: _____ Group: _____

Subscriber: _____ DOB: _____ Employer: _____

ACCIDENT/WORKER'S COMPENSATION INFORMATION

Current problem is a result of a: ☐ Car Accident ☐ Work Related Accident (W/C) ☐ Other: _____

Date of Accident: _____

If Accident, is there litigation pending? ☐ Yes ☐ No ☐ N/A

Insurance Co: _____ Claim#: _____

Adjuster Name: _____ Phone: _____ Fax: _____

REFERRING PHYSICIAN INFORMATION

Physician Name_____Specialty: _____

Phone: _____ Fax Number: _____

PRIMARY CARE PHYSICIAN INFORMATION

Physician Name_____

Phone: _____ Fax Number: _____

PRESENT ILLNESS

Reason for your visit: _____

Symptoms : _____

_____

_____

Date: _____ Chart: _____

PAST MEDICAL HISTORY

Current Medical Problems and Past Significant Illnesses

_____

_____

_____

_____

PAST SURGICAL HISTORY

Past Surgeries and Their Approximate Dates

_____

_____

_____

_____

FAMILY HISTORY

Please list any medical conditions in your family such as asthma, high blood pressure, heart attacks, kidney problems, diabetes, seizures, strokes, aneurysms, cancers, etc.

Mother: _____ Father: _____

Sibling: _____ Sibling: _____

Others relative: _____

Do you have children? ☐ Yes ☐ No If yes, any medical conditions?: _____

MEDICATION

Allergies and Reaction: _____

Pharmacy: _____ Location (City/State): _____

MEDICATION LIST

MEDICATION	DOSE & FREQUENCY	**MEDICATION**	DOSE & FREQUENCY

Date: _____ Chart: _____

SOCIAL HISTORY

Height: _____ Weight: _____ Body Mass Index (BMI): _____

Gender:

☐ Male ☐ Female

Race:

☐ White ☐ Black ☐ Asian ☐ Other: _____

Ethnicity:

☐ Hispanic/Latino ☐ Not Hispanic/Latino

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner ☐ Other: _____

Language:

☐ English ☐ Spanish ☐ Portuguese ☐ American Sign ☐ Other: _____

Currently working? ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Retired ☐ Other _____

Are you a student? ☐ Yes ☐ No

Currently disabled? ☐ Yes ☐ No

If disabled, by what physician: _____

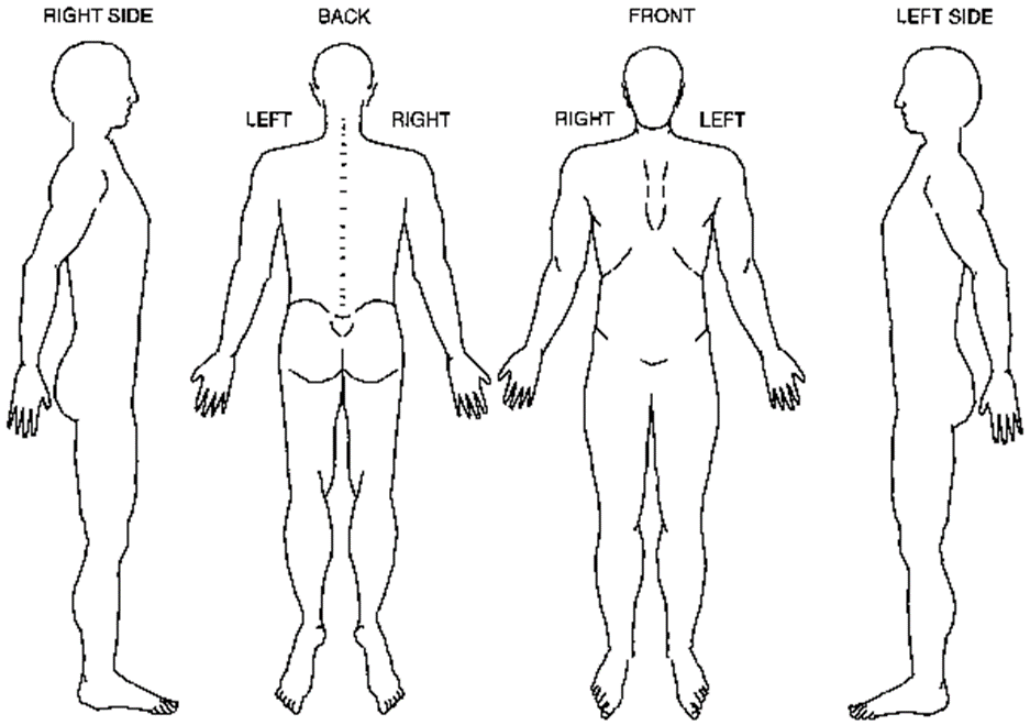
Do you smoke? ☐ Yes ☐ No

If you quit, when did you quit? _____ How many packs/day? _____

For how long? _____

Do you drink alcohol? ☐ Yes ☐ No

How many drinks/week? _____



Pain Drawing – Mark the area on the body where you feel pain, numbness or tingling

Date: _____ Chart: _____

REVIEW OF SYSTEMS

Please circle the medical condition(s) below which apply to you either now or in the past.

Cardiovascular

Chest pain/pressure	Fainting	Heart attack	Heart defect	Heart murmur
High blood pressure	Low blood pressure	Leg Swelling		

Constitutional

Altered taste/smell	Cancer	Change in appetite	Excessive sleepiness	Fatigue
Fever	Depression	Anxiety	Recent sore throat	Sleep apnea
Weight loss or gain				

Ears, Nose, & Throat

Hearing loss	Mouth sores	Ringing in ears	Sinus disease	Trouble swallowing

Endocrine

Lymph node swelling	Pituitary disorder	Thyroid disease		

Eyes

Blurred vision	Cataracts	Double vision	Glaucoma	Macular degeneration
Peripheral vision issue	Visual impairment			

Gastrointestinal

Black stool	Constipation	Diarrhea	Gall bladder problems	Ulcer Vomiting

Genitourinary

Blood in urine	Change in habits	Infections in urine	Kidney disease	Kidney stones
Loss of control	Painful urination	Urinary urgency	Vaginal bleeding	

Hematologic/Lymphatic

Anemia	Blood disorder	Circulatory problems	Diabetes	Dry eyes/mouth
Low blood sugar	Hepatitis	HIV/AIDS	Sickle cell disease	

Musculoskeletal

Connective tissue disorder	Low back pain	Neck pain	Joint pain	Joint replacement
Joint swelling				

Neurological

Balance difficulty	Choking	Clumsiness	Concussion	Confusion
Concentration difficulty	Dizziness	Drooling	Falls	Hallucinations
Headache	Loss of consciousness	Memory problems	Muscle twitching	Nausea
Numbness	Personality change	Seizure	Shooting pains	Smelling difficulty
Stroke	Tasting difficulty	Tingling sensation	Vertigo	Walking difficulty

Respiratory

Asthma	Bronchitis	Chronic cough	COPD	Emphysema
Pneumonia	Shortness of breath	Trouble breathing	Tuberculosis	Wheezing

Skin

Birth marks	Psoriasis	Skin rashes	Melanoma

Other Pertinent Information:

COMPLETED BY:

_____ _____

SIGNATURE DATE

REVIEWED BY:

_____ _____

SIGNATURE DATE