Neurosurgical Associates of Southwestern Connecticut, P.C.

# PATIENT QUESTIONNAIRE

**Date:**_____ **Chart #:**_____

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

**Telephone #: Home**_____ **Cell**_____ **Work**_____

**E-mail Address:** _____ **Height:**_____ **Weight:**_____

**Primary Care Physician:**_____ **Referring Physician:**_____

**********

*(REQUIRED BY MEDICARE)*

**Race:** ☐White ☐Black ☐Asian ☐Other _____ **Ethnicity:** ☐Hispanic/Latino ☐Other

**Language Spoken:** ☐English ☐Spanish ☐Portuguese ☐American Sign ☐Other_____

## *TOBACCO USE*

☐Smokes Everyday ☐Occasional User ☐Former/Quit ☐Never Smoked ☐Other_____

## *HISTORY*

**Reason for today's visit:**_____

**If current problem is the result of a:** ***(Check all that apply)***

☐Car Accident ☐Work Related Accident (W/C) ☐Other **Date of Accident:**_____

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

**List any major illnesses and/or injuries:**

_____

_____

**List any Surgeries/Hospitalizations:** **Year** **Complications**

_____

_____

_____

_____

**List allergies you have (including drugs, food, other {latex}):**

| Allergy | Type of Reaction | Allergy | Type of Reaction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Have you ever had problems with anesthesia?** ☐Yes ☐No

| Current Medication(s) | Dose | Frequency | Current Medication(s) | Dose | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Family History

| Family Member | Alive | Deceased | Age | Health status/cause of death |
|---|---|---|---|---|
| **Mother** | ___ | _____ | ___ | _____ |
| **Father** | ___ | _____ | ___ | _____ |
| **Siblings** | ___ | _____ | ___ | _____ |
| _____ | ___ | _____ | ___ | _____ |
| _____ | ___ | _____ | ___ | _____ |

## Social History

**Occupation:** _____

**Marital Status:** ___ **Single** ___ **Married** ___ **Divorced** ___ **Widowed**

**Do you have any children?** ___ **Yes** ___ **No** **How Many?:** _____

**Do you live alone?** ___ **Yes** ___ **No** **Who do you live with?:** _____

**Do you drink alcohol?** ___ **No, never (or rarely)** ___ **No, but I used to**
___ **Yes, Daily** ___ **Yes, 1 or more times a week** ___ **Yes, 1 or more times a month**

## Review of Systems

***(Please circle any of the following that pertain to you.)***

**Constitutional**
Fever Weight Loss Excessive Fatigue Night Sweats

**Eyes**
Eye Injuries Glaucoma Cataracts

**Ear, Nose, Throat and Mouth**
Hearing Loss Ringing in Ears Balance Disturbance
Inability to Smell Sinus Problems Sinus Headaches

**Cardiovascular**
High Blood Pressure Irregular Pulse Heart Murmur
High Cholesterol Swelling in Feet or Hands

**Respiratory**
Asthma Emphysema Shortness of Breath Bronchitis

**Gastrointestinal**
Indigestion or Pain with Eating Nausea Vomiting
Liver Disease Ulcers Gastritis

**Genitourinary**
Urinary Tract Infections Painful Urination Blood in your Urine
Difficulty Starting or Stopping Stream Incontinence

**Musculoskeletal**
Weakness in Arm Weakness in Leg Back Pain Neck Pain
Arm Pain Leg Pain Joint Pain or Swelling Arthritis

**Integumentary**
Skin Disease

**Neurological**

| | | |
|---|---|---|
| Fainting Spells or "Blacking Out" | Face Weakness | Seizures |
| Problems with your Memory | Disorientation | |
| Difficulty with your Speech | Inability to Concentrate | |
| Coordination in Arm and/or Legs | Double or Blurred Vision | |

**Psychiatric**
Anxiety Depression

**Endocrine**
Excessive Thirst or Urination Hormone Problems

**Hematologic/Lymphatic**
Anemia Bleeding Tendencies Blood Transfusion

**Allergic/Immunologic**
Inhalant (nasal) Allergies Immunologic Disorders Food Allergies

**Pain Drawing – Please fill this out completely. Mark the area on the body where you feel the described sensation. Use the appropriate symbol. Mark the areas of radiating pain and include all affected areas.**

**Symbols**

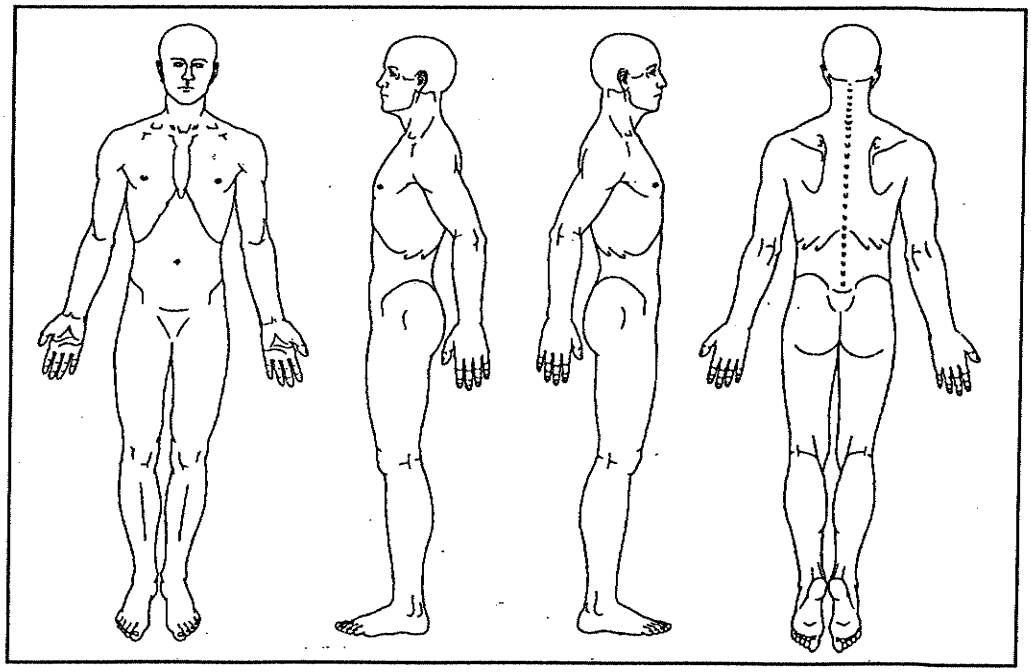
**Numbness – N**

**Burning Pain – B**

**Aching Pain – A**

**Pins & Needles – P**

**Stabbing Pain - S**



**The above information is accurate to the best of my knowledge.**

**Patient Signature** **Date**

**I have reviewed the above information with the patient.**

**Physician Signature** **Date**

Revised 09/11/12 – PD