PATIENT HISTORY FOR YAKIMA NEUROSURGERY ASSOCIATES

NAME: ______________________________ **DATE:** ______________

REFERRED BY: ______________________________

AGE: ______________________ **(Circle) Right or Left Handed**

CHIEF COMPLAINT: ______________________________

AUTO ACCIDENT: Yes/No ______________ **WORK INJURY: Yes/No**______________

LOCATION: ______________________________
Where is the problem or pain?

SEVERITY: ______________________ **DURATION:** ______________
How severe is the problem/pain? **When did it start?**

TIMING: ______________________**CONTEXT:**______________________
Does problem/pain occur at a certain time? **Where were you when pain started?**

ASSOCIATED SYMPTOMS: ______________________________

MODIFYING FACTORS: ______________________________

Have you ever had the same problem before? ______________________________

If Yes, when/where: ______________________________

MEDICATIONS:
List ALL medications, prescriptions, over the counter and/or herbal:

____

____

MEDICINE/ FOOD ALLERGIES: ______________________________

PAST HISTORY:

LIST ANY PAST SURGERY (S): ______________________________

Please Circle:

Diabetes	NO	YES	Convulsions	NO	YES
High Blood Pressure	NO	YES	Bleeding Tendency	NO	YES
Cancer	NO	YES	Acute Infections	NO	YES
Stroke	NO	YES	Venereal Disease No	NO	YES
Heart Trouble	NO	YES	Hereditary defects	NO	YES
Arthritis	NO	YES			

SYSTEMS REVIEW: Please indicate if you are currently or regularly experiencing any of the following:

CONSTITUTIONAL SYSTOMS:

Good general health lately	NO	YES
Recent weight loss	NO	YES
Fever	NO	YES
Fatigue	NO	YES
Headaches	NO	YES

EYES:

Eye disease or injury	NO	YES
Wear glasses/contact lens	NO	YES
Blurred vision	NO	YES
Glaucoma	NO	YES

EAR/ NOSE/ MOUTH/ THROAT:

Hearing loss	NO	YES
Earache or drainage	NO	YES
Chronic sinus/rhinitis	NO	YES
Nose bleeds	NO	YES
Mouth sores	NO	YES
Bleeding gums	NO	YES
Bad breath or bad taste	NO	YES
Sore throat or voice change	NO	YES
Swollen glands in neck	NO	YES

CARDIOVASCULAR:

Heart trouble	NO	YES
Chest pain/ angina pectoria	NO	YES
Palpitations	NO	YES
Shortness of breathe	NO	YES
Asthma or wheezing	NO	YES

RESPIRATORY:

Chronic/ frequent cough	NO	YES
Spitting up blood	NO	YES
Shortness of breathe	NO	YES
Swelling foot/ ankle/ hands	NO	YES

GASTROINTESTINAL:

Loss of appetite	NO	YES
Change in bowel movements	NO	YES
Nausea or vomiting	NO	YES
Frequent diarrhea	NO	YES
Painful bowel movements	NO	YES
Constipation	NO	YES
Rectal bleeding	NO	YES
Blood in stool	NO	YES
Abdominal pain/ heartburn	NO	YES
Ulcer stomach/duodenal	NO	YES

MUSCULOSKELETAL:

Joint pain	NO	YES
Joint stiffness	NO	YES
Weakness	NO	YES
Back	NO	YES
Cold extremities	NO	YES
Difficulty walking	NO	YES

INTEGUMENTARY:

Rash or Itching	NO	YES
Change in skin color	NO	YES
Varicose veins	NO	YES
Breast pains	NO	YES
Breast lumps	NO	YES
Breast discharge	NO	YES

NEUROLOGICAL:

Headaches, frequent	NO	YES
Light headed or dizzy	NO	YES
Convulsions/ seizures	NO	YES
Numbness/ tingling	NO	YES
Tremors	NO	YES
Paralysis	NO	YES
Stroke	NO	YES
Head injury	NO	YES

PSYCHIATRIC:

Memory loss/ confusion	NO	YES
Nervousness	NO	YES
Depression	NO	YES
Insomnia	NO	YES

ENDOCRINE:

Glandular	NO	YES
Hormone problems	NO	YES
Thyroid disease	NO	YES
Excessive urination	NO	YES
Hot/ cold intolerance	NO	YES
Skin dryness	NO	YES
Change hat/ glove size	NO	YES

HEMATOLOGIC/LYMPHATIC:

Blood Diseases	NO	YES
Cuts slow to heal	NO	YES
Tendency to bleed/ bruise	NO	YES
Anemia	NO	YES
Phlebitis	NO	YES
Past transfusions	NO	YES
Enlarged glands	NO	YES

GENITOURINARY:

Frequent urination	NO	YES	Incontinent of urine	NO	YES
Burning/ painful urination	NO	YES	Dribbling	NO	YES
Change in force of strain	NO	YES	Male- Testicle pain	NO	YES
Kidney stones	NO	YES	Female- Irregular periods	NO	YES
Sexual difficulty	NO	YES	Date of last Pap smear	___________	
Female- Pain w/ periods	NO	YES	# of miscarriages_______	NO	YES
Vaginal discharge	NO	YES	Blood in urine	NO	YES
#of Pregnancies ____________	NO	YES			

SOCIAL HISTORY:

Marital Status: Single______ Married______ Separated ______ Divorced ______ Widowed ______

Number of children: ____

Use of Alcohol: Never ______ Barely ______ Moderate ______ Daily ______

Use of tobacco: Never ______ Barely ______ Moderate ______ Daily ______

Use of drugs: Never ______ Barely ______ Moderate ______ Daily ______

Excessive exposure to: Fumes ______ Dust ______ Solvents ______ Noise ______

Are you currently working: YES NO

Occupation (Type of work): __________________________If yes, Full duty or Modified: ____________

If no, Date Last Worked: ____________________________

Name of Family Physician: ____

FAMILY HISTORY:

	AGE:	Diabetes, cancer, high blood pressure, other? If deceased; known cause of death.
Father:	______	____
Mother:	______	____
Siblings:	______	____
	______	____
	______	____
Spouse:	______	____
Children:	______	____
	______	____