ALEXANDRIA NEUROSURGICAL CLINIC
Initial Evaluation
Dr. Gregory Dowd

Patient Name:_____ Age:_____

Please state briefly the main issue for your visit:_____
_____
_____

Have you ever had SPINAL SURGERY? YES or NO
If so, what type and when? _____
_____

Injury? Yes No At work? Yes No Auto Accident? Yes No
Date of Injury?_____

Right or Left Handed:_____

SURGICAL HISTORY:

_____ Heart
_____ Knee
_____ Hysterectomy
_____ Gallbladder
_____ Appendectomy

Other: _____
_____
_____

MEDICAL HISTORY:

_____ Diabetes
_____ High Blood Pressure
_____ Bleeding Problems
_____ Heart Condition
_____ Stroke
_____ Cancer

Other: _____
_____
_____

Are you on any Anti-Coagulants / Blood Thinners? Yes or No
(Coumadin, Plavix, Aspirin, Pradaxa, Pletal)

Have you taken Steroids / Cortisone in the past 6 months? Yes or No

Current Medications:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies: _____

SOCIAL HISTORY:

Married YES or NO

Children: YES or NO If so, how many? _____

Tobacco YES or NO If so, how much? _____

Alcohol YES or NO If so, how much? _____

Occupation: _____
When was the last time you worked a full day? _____

HAVE YOU HAD PROBLEMS WITH ANY OF THE FOLLOWING?
Neurological Review of Systems:

_____Headaches	_____Loss of Hearing/Tinnitus	_____Memory Loss
_____Confusion	_____Loss of Taste	_____Loss of Smell
_____Vision Changes	_____Walking/Gait Difficulties	_____Speech Problems
_____Fainting/Syncope	_____Personality Changes	_____Seizures/Epilepsy
_____Vertigo/Dizziness	_____Hoarseness/Voice Changes	

General Review of Systems:

_____Recent Bleeding Problems	_____Change in Appetite
_____Chronic Sore Throat	_____Weight Loss
_____Chronic Fatigue/Tiredness	_____Bladder/Urinary Symptoms
_____Shortness of Breath	_____Chronic Skin Problems
_____Stomach/Intestinal Problems	_____Joint Problems
_____Seizures/Epilepsy	_____Change in Bowel/Bladder Habits
_____Depression	

Family History:

	FATHER	MOTHER	BROTHER	SISTER
Heart Disease	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____
Bleeding Problems	_____	_____	_____	_____
Seizure/Epilepsy	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____

PATIENT SIGNATURE:_____ DATE:_____
The above is true and correct to the best of my knowledge.

PHYSICIAN SIGNATURE:_____ DATE:_____
I have reviewed the above medical history with the patient.