Alexandria Neurosurgical Clinic
INTITIAL VISIT

Patient Name: _____ Date: _____

Patient Age: _____

Reason for Office Visit

1. Circle those that apply:

   Back Pain Neck Pain Arm Pain Leg Pain

   Other: _____

   _____

2. Were you injured: Yes ☐ No ☐ At work? Yes ☐ No ☐

   Auto Accident? Yes ☐ No ☐ Date of injury? _____

3. Have you been treated for this current problem by another doctor? Yes ☐ No ☐

   Name of physician: _____ Date last seen: _____

4. Have you ever had Neck/Back problems before? Yes ☐ No ☐

   If so, what kind? _____

   When? _____

Past Medical History

Please indicate which of the following problems you have been diagnosed with or treated for in the past:

- ☐ Blood Disorders (Anemia, Free Bleeding, Sickle Cell)
- ☐ Pneumonia
- ☐ Chronic Lung Disease (Asthma, Emphysema)
- ☐ Heart Trouble
- ☐ Hypertension
- ☐ Liver Problems
- ☐ Seizures
- ☐ Cancer: What kind? _____
- ☐ Ulcers
- ☐ Stroke
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Meningitis
- ☐ Bowel Problems
- ☐ Vascular Disease

Patient Name: _____ Date: _____

Past Surgery History

1. Have you ever had spinal surgery? Yes ☐ No ☐
   If so, what kind and when? _____
   _____

2. Please list any other surgery you have had: _____
   _____

Social History

1. Marital Status: Married Separated Widowed Single Divorced
2. Education: Grade School High School College Post Grad Vocational
3. Number of children: _____
4. Do you smoke currently? Yes ☐ No ☐ Have you smoked in the past? Yes ☐ No ☐
   If yes, indicate how many packs per day: _____ How long? _____ Date Quit: _____
5. Do you currently or have you used in the past illegal drugs? Yes ☐ No ☐
   If so, what kind? _____ Date Quit: _____
6. Do you drink alcohol currently? Yes ☐ No ☐ In the past? Yes ☐ No ☐ Date Quit: _____
   If yes, please indicate type and average amount: _____
7. Occupation (Please give a brief description) _____
   _____
   When did you last work a full day? _____

Family History

Please indicate if any family members (mother, father, brother, sister, children) have had any of the following problems: If so, who?

Blood Disorders: _____ Kidney Disease: _____
Lung Disease: _____ Stroke: _____
Heart Trouble: _____ Diabetes: _____
Hypertension: _____ Seizures: _____
Vascular Disease: _____ Cancer: _____
What kind? _____

Patient Name: _____ Date: _____

Review of Systems

Please indicate if you have problems with any of the following:

GENERAL
- ☐ Skin rash
- ☐ Weakness/lethargy
- ☐ Loss of interest in eating
- ☐ Always hungry
- ☐ Tend to be hot or cold
- ☐ Chills or night sweats
- ☐ Sleeping difficulties
- ☐ Weight loss
- ☐ Weight gain

HEAD
- ☐ Frequent headaches
- ☐ Dizzy spells
- ☐ Fainting spells

EYES
- ☐ Wear glasses
- ☐ Eyesight worsening
- ☐ Double vision
- ☐ Eye pain or itching

EARS
- ☐ Deafness
- ☐ Earaches or drainage
- ☐ Noise in ears

THROAT
- ☐ Sore throat or tongue
- ☐ Hoarse voice
- ☐ Dental problems
- ☐ Goiter/thyroid trouble
- ☐ Neck pains or lumps

LUNGS
- ☐ Wheezing/coughing spells
- ☐ Cough up phlegm
- ☐ Shortness of breath
- ☐ Emphysema
- ☐ Cough up blood
- ☐ Exposed to TB
- ☐ Asthma

HEART
- ☐ Heart racing/palpitations
- ☐ High blood pressure
- ☐ Swollen feet or ankles
- ☐ Chest pains
- ☐ Heart attack
- ☐ Heart murmur

GASTROINTESTINAL
- ☐ Heart burn or indigestions
- ☐ Nausea or vomiting
- ☐ Jaundice
- ☐ Difficulty swallowing
- ☐ Stomach pains
- ☐ Vomiting blood
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Black or bloody stools
- ☐ Stomach ulcers
- ☐ Pain in rectum
- ☐ Hemorrhoids
- ☐ Amoeba/parasites

GENITOURINARY
- ☐ Frequent urination
- ☐ Burning on urination
- ☐ Pus or blood in urine
- ☐ Difficulty in starting urine
- ☐ Dribbling with cough, etc.
- ☐ Other kidney disease
- ☐ Sex difficulties
- ☐ Kidney stone

NEUROLOGIC
- ☐ Convulsions/seizures
- ☐ Stroke/paralysis
- ☐ Difficulty with decisions
- ☐ Memory problems
- ☐ Cry often/depressed
- ☐ Worry a lot
- ☐ Considered suicide
- ☐ Numbness or tingling
- ☐ Weakness

MISCELLANEOUS
- ☐ Blood transfusions
- ☐ Bleed/bruise easily
- ☐ Anemia/low blood
- ☐ Blood disease
- ☐ Enlarged glands/nodes
- ☐ Aching muscles/joints
- ☐ Varicose veins
- ☐ Leg cramps/pains
- ☐ Painful feet
- ☐ Cancer
- ☐ Prolonged fever

Patient Name: _____ Date: _____

Medication History

1. Please list all the medications you are currently taking (prescription and non-prescription and any supplements or herbals) and dose of each:

   Name/Dosage

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

2. Do you use blood thinners (ex: Aspirin, Plavix, Coumadin, BC Powder)? Yes ☐ No ☐

3. Are you allergic to any medications? Yes ☐ No ☐

   If yes, please list them below and describe reaction:

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Are there any pain medications you know you cannot take? Yes ☐ No ☐

   If yes, please list them below and give reason:

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____