Alexandria Neurosurgical Clinic
INTITAL 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)  ☐ Ulcers
☐ Pneumonia  ☐ Stroke
☐ Chronic Lung Disease (Asthma, Emphysema)  ☐ Diabetes
☐ Heart Trouble  ☐ Kidney Disease
☐ Hypertension  ☐ Meningitis
☐ Liver Problems  ☐ Bowel Problems
☐ Seizures  ☐ Vascular Disease
☐ Cancer: What kind? ___________________________
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: 

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

**GASTROINTESTINAL**
- Heart burn or indigestions
- Nausea or vomiting
- Jaundice
- Difficulty or vomiting
- Stomach pains
- Vomiting swallowing
- Stomach ulcers
- Constipation
- Change in bowel habits
- Diarrhea
- Black or bloody stools
- Pains 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
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
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________