Alexandria Neurosurgical Clinic
INTITIAL VISIT
Dr. M. Lawrence Drerup

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

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
_____	_____
_____	_____
_____	_____
_____	_____

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