NEUROSURGICAL ASSOCIATES OF CENTRAL NEW YORK, LLP
MEDICAL HISTORY AND PATIENT INFORMATION FORM

Patient Name: _____ **Today's Date:** _____

Doctor You Are Seeing Today: _____ **DOB:** _____

Primary Care Physician: _____ **Referring Physician:** _____

Pharmacy: _____ **Address:** _____ **Phone Number:** _____

Reason for today's visit: _____

Is the visit the result of (Please circle all that apply): Car Accident Work Accident Other Accident

ALLERGIES

Are you allergic to?	Type of Reaction
__ Amoxicillin/Penicillin	_____
__ Codeine	_____
__ Contrast Dye	_____
__ Sulfa	_____
__ Latex/Rubber	_____
__ Tape	_____
__ Other: _____	_____

CURRENT MEDICATIONS
(Please List Dose and How Often You Take)

Are you taking blood thinners: YES NO

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Attach list if taking additional medications

MEDICAL HISTORY: Please Circle Yes or No for Each Item

Allergies	Y	N	Cataracts	Y	N	Hypertension	Y	N
Anemia	Y	N	Congestive Heart Failure	Y	N	Kidney Disease	Y	N
Anxiety	Y	N	Clotting Disorder	Y	N	Myocardial Infarction	Y	N
Arrhythmia	Y	N	Depression	Y	N	Nerve/Muscle Disease	Y	N
Arthritis	Y	N	Diabetes Mellitus	Y	N	Osteoporosis	Y	N
Asthma	Y	N	GERD	Y	N	Seizures	Y	N
Low Back Pain	Y	N	Glaucoma	Y	N	Stroke	Y	N
Blood Transfusion	Y	N	Gout	Y	N	Substance Abuse	Y	N
Chronic Bronchitis	Y	N	Headaches	Y	N	Thyroid Disease	Y	N
Coronary Artery Disease	Y	N	Heart Murmur	Y	N	Tuberculosis	Y	N
Cancer	Y	N	HIV/AIDS	Y	N	Ulcers	Y	N

Other: _____

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SURGICAL HISTORY: Please Circle Yes or No for Each Item

Have you had any of the following surgeries:

		Date			Date			Date
Appendectomy	Y N	_____	Colonoscopy	Y N	_____	Ovary Removal	Y N	_____
Breast Surgery	Y N	_____	Colostomy	Y N	_____	Prostate	Y N	_____
Breast Biopsy	Y N	_____	C-Section	Y N	_____	Small Intestine	Y N	_____
Breast Reconst	Y N	_____	Fracture	Y N	_____	Spine	Y N	_____
CABG	Y N	_____	Gastroplasty	Y N	_____	Tonsillectomy	Y N	_____
Cataracts	Y N	_____	Hernia	Y N	_____	Tubal Ligation	Y N	_____
Cholecystecomy	Y N	_____	Hysterectomy	Y N	_____	Valve Replace	Y N	_____
Cholectomy	Y N	_____	Joint Replace	Y N	_____	Vasectomy	Y N	_____
Colon Surgery	Y N	_____	Mastectomy	Y N	_____			
Other	Y N	_____						

SOCIAL HISTORY: Please Circle Yes or No for Each Item and Complete Other Information

Do you drink alcohol: Y N

If yes, how many drinks per week:

____ Glasses of wine

____ Cans of beer

____ Shots of liquor

____ Drinks containing greater than .5 oz of alcohol

Do you use any drugs: Y N **Times per week:** _____

Type: _____ **(Note: These are other drugs not listed on your medication list.)**

Do you use tobacco (ex: cigarettes, cigars)? Y N **Number of years smoking:** _____

Quit date: _____

Do you use smokeless tobacco: Y N

Quit date: _____

Are you ready to quit smoking/tobacco use? Y N

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FAMILY HISTORY: Please Circle Yes or No for Each Item and Indicate Family Member

Problem	Does it Run in Your Family?	Family Members with History – (Please indicated if maternal or paternal grandparent, if listed)
Alcohol Abuse	__ Yes __ No	_____
Arthritis	__ Yes __ No	_____
Asthma	__ Yes __ No	_____
Cancer	__ Yes __ No	_____
COPD	__ Yes __ No	_____
Depression	__ Yes __ No	_____
Diabetes	__ Yes __ No	_____
Drug Abuse	__ Yes __ No	_____
Early Death	__ Yes __ No	_____
Heart Disease	__ Yes __ No	_____
High Cholesterol	__ Yes __ No	_____
Hypertension	__ Yes __ No	_____
Kidney Disease	__ Yes __ No	_____
Learning Disorder	__ Yes __ No	_____
Mental Illness	__ Yes __ No	_____
Stroke	__ Yes __ No	_____
Other: _____		_____
Other: _____		_____
Other: _____		_____
Other: _____		_____

The information provided is accurate to the best of my knowledge.

_____ _____

Patient Signature **Date**

NEUROSURGICAL ASSOCIATES OF CENTRAL NEW YORK, LLP

PATIENT NAME: _____ **DATE OF BIRTH:** _____

ARE YOU CURRENTLY OR HAVE YOU HAD PROBLEMS WITH (Please circle yes or no for each item listed)

CONSTITUTIONAL

Activity Change	Y	N
Appetite Change	Y	N
Chills	Y	N
Excessive Sweating	Y	N
Fatigue	Y	N
Fever	Y	N
Unplanned Weight Loss	Y	N

EAR, NOSE & THROAT

Facial Swelling	Y	N
Neck Pain	Y	N
Neck Stiffness	Y	N
Ear Discharge	Y	N
Hearing Loss	Y	N
Ear Pain	Y	N
Ringing in Ears	Y	N
Nosebleeds	Y	N
Congestion	Y	N
Clear Fluid from Nose	Y	N
Postnasal Drip	Y	N
Sneezing	Y	N
Sinus Pressure	Y	N
Dental Problems	Y	N
Drooling	Y	N
Mouth Sores	Y	N
Sore Throat	Y	N
Trouble Swallowing	Y	N
Voice Change	Y	N

EYES

Eye Discharge	Y	N
Eye Itching	Y	N
Eye Pain	Y	N
Eye Redness	Y	N
Lights Hurts Eyes	Y	N
Visual Disturbance	Y	N

RESPIRATORY

Sleep Apnea	Y	N
Chest Tightness	Y	N
Choking	Y	N
Cough	Y	N
Shortness of Breath	Y	N
Trouble Breathing	Y	N
Wheezing	Y	N

CARDIOVASCULAR

Chest Pain	Y	N
Leg Swelling	Y	N
Heart Pounding	Y	N

GASTROINTESTINAL

Abdominal Distension	Y	N
Abdominal Pain	Y	N
Anal Bleeding	Y	N
Blood in Stool	Y	N
Constipation	Y	N
Diarrhea	Y	N
Nausea	Y	N
Rectal Pain	Y	N
Vomiting	Y	N

GENITOURINARY

Difficulty Urinating	Y	N
Painful Sex	Y	N
Painful Urination	Y	N
Problems Bed Wetting	Y	N
Flank Pain	Y	N
Frequency	Y	N
Genital Sore	Y	N
Blood in Urine	Y	N
Menstrual Problems	Y	N
Pelvic Pain	Y	N
Penile Swelling	Y	N
Scrotal Swelling	Y	N
Testicular Pain	Y	N
Urgency	Y	N
Urine Decreased	Y	N
Vaginal Bleeding	Y	N
Vaginal/Penile Discharge	Y	N
Vaginal/Penile Pain	Y	N

MUSCULOSKELETAL

Joint Pain	Y	N
Back Bain	Y	N
Gait Problem	Y	N
Joint Swelling	Y	N
Muscle Pain	Y	N

SKIN

Color Change	Y	N
Pale Color	Y	N
Rash	Y	N
Wound	Y	N

NEUROLOGICAL

Dizziness	Y	N
Facial Asymmetry	Y	N
Headaches	Y	N
Light-Headed	Y	N
Numbness	Y	N
Seizures	Y	N
Speech Difficulty	Y	N
Fainting Spells	Y	N
Tremors	Y	N
Weakness	Y	N

HEMATOLOGIC

Swollen Glands	Y	N
Bruise/Bleed Easily	Y	N

PSYCHIATRIC

Agitation	Y	N
Behavior Problems	Y	N
Confusion	Y	N
Decreased Concentration	Y	N
Bad Moods	Y	N
Hallucinations	Y	N
Hyperactive	Y	N
Nervous/Anxious	Y	N
Self-Injury	Y	N
Sleep Disturbance	Y	N
Suicidal Thoughts	Y	N