



SEATTLE NEUROSURGERY

PATIENT MEDICAL HISTORY

PATIENT NAME: _____
 LAST FIRST MIDDLE INITIAL

DATE OF BIRTH: ____/____/____ GENDER: MALE FEMALE AGE: _____ HEIGHT: _____ WEIGHT: _____

OCCUPATION: _____ RETIRED? NO YES

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

Is this a work related injury? NO YES

MARITAL STATUS: SINGLE MARRIED SEPARATED WIDOW/ER DEPENDENT DOMESTIC PARTNER

RACE: WHITE/CAUCASIAN BLACK/AFRICAN AMERICAN NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ASIAN
 AMERICAN INDIAN OR ALASKA NATIVE PREFER NOT TO DISCLOSE UNKNOWN OTHER _____

ETHNICITY: HISPANIC OR LATINO NOT HISPANIC OR LATINO PREFER NOT TO DISCLOSE UNKNOWN

PREFERRED LANGUAGE: _____

PERSONAL MEDICAL HISTORY

(Please check if YOU currently have or had the following diseases/conditions and check any that apply.)

- | | | |
|------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> THYROID DISORDER | <input type="checkbox"/> ANTIBIOTIC RESISTANT INFECTION/
MRSA |
| <input type="checkbox"/> EPILEPSY/SEIZURES/CONVULSIONS | <input type="checkbox"/> LIVER DISEASES/HEPATITIS
TYPE: _____ | <input type="checkbox"/> ANXIETY/DEPRESSION |
| <input type="checkbox"/> STROKE/TIA | <input type="checkbox"/> KIDNEY DISEASE/KIDNEY STONES | <input type="checkbox"/> HIV |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> PROSTATE DISEASE | <input type="checkbox"/> STEROID USE |
| <input type="checkbox"/> HEART PROBLEMS/HEART ATTACK/
IRREGULAR HEARTBEAT | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> METAL ALLERGY |
| <input type="checkbox"/> DVT/PULMONARY EMBOLISM/
BLOOD CLOTS | <input type="checkbox"/> GOUT | <input type="checkbox"/> ANESTHESIA DIFFICULTIES/
MALIGNANT HYPERTHERMIA |
| <input type="checkbox"/> ANEMIA/BLEEDING DISORDER | <input type="checkbox"/> OSTEOPOROSIS/OSTEOPENIA | <input type="checkbox"/> CONTINUOUS POSITIVE AIRWAY
PRESSURE (CPAP) |
| <input type="checkbox"/> ASTHMA/COPD/EMPHYSEMA/
BREATHING PROBLEMS | <input type="checkbox"/> CANCER
TYPE: _____ | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> COMMUNICABLE DISEASES | <input type="checkbox"/> NONE |
| | <input type="checkbox"/> TUBERCULOSIS | |

PREVIOUS SURGERIES

(Please list ALL previous surgeries and date.)

PROCEDURE/DATE	PROCEDURE/DATE
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

MEDICATIONS

(Please list ALL medications including prescriptions, over-the-counter medications and blood thinning medications such as Coumadin, Plavix, aspirin, etc.)

MEDICATION	DOSE	HOW OFTEN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

ALLERGIES

(Please list ALL allergies including contrast dyes, metal, latex, medication or other.)

NAME	SPECIFY REACTION (hives, rash, breathing difficulty, anaphylaxis)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

FAMILY MEDICAL HISTORY

(Please check if anyone in your FAMILY has or had the following diseases/conditions; check the applicable condition and state your relationship.)

<input type="checkbox"/> GLAUCOMA _____	<input type="checkbox"/> LIVER DISEASES/HEPATITIS, TYPE: _____
<input type="checkbox"/> EPILEPSY/SEIZURES/CONVULSIONS _____	<input type="checkbox"/> KIDNEY PROBLEMS _____
<input type="checkbox"/> HIGH BLOOD PRESSURE _____	<input type="checkbox"/> ARTHRITIS _____
<input type="checkbox"/> HEART PROBLEMS/HEART ATTACK/IRREGULAR HEARTBEAT/ STROKE _____	<input type="checkbox"/> GOUT _____
<input type="checkbox"/> DVT/PULMONARY EMBOLISM/BLOOD CLOTS _____	<input type="checkbox"/> OSTEOPOROSIS/OSTEOPENIA _____
<input type="checkbox"/> ANEMIA/BLEEDING DISORDER _____	<input type="checkbox"/> CANCER, TYPE: _____
<input type="checkbox"/> ASTHMA/BREATHING PROBLEMS/EMPHYSEMA _____	<input type="checkbox"/> METAL ALLERGY _____
<input type="checkbox"/> DIABETES _____	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> THYROID DISORDER _____	<input type="checkbox"/> NONE

SOCIAL HISTORY

Do you use tobacco?	<input type="checkbox"/> NO <input type="checkbox"/> YES	Packs Per Day: _____	If Quit, When: _____
Do you drink alcohol?	<input type="checkbox"/> NO <input type="checkbox"/> YES	How Much/Often: _____	If Quit, When: _____
Current or history of drug use?	<input type="checkbox"/> NO <input type="checkbox"/> YES	Type: _____	If Quit, When: _____
Are you pregnant?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> POSSIBLY		
How many children do you have? _____		Number living with you? _____	

REVIEW OF SYSTEMS

(Please check if YOU are experiencing any of the following symptoms and check any that apply.)

<input type="checkbox"/> FEVER	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> PROSTATE PROBLEMS
<input type="checkbox"/> WEIGHT LOSS OR GAIN	<input type="checkbox"/> PALPITATIONS	<input type="checkbox"/> BLEEDING PROBLEMS
<input type="checkbox"/> CHILLS	<input type="checkbox"/> FAINTING	<input type="checkbox"/> EASY BRUISING
<input type="checkbox"/> FATIGUE	<input type="checkbox"/> MURMURS	<input type="checkbox"/> JOINT SWELLING
<input type="checkbox"/> SORE THROAT	<input type="checkbox"/> COUGH	<input type="checkbox"/> STIFFNESS
<input type="checkbox"/> DIFFICULTY SWALLOWING	<input type="checkbox"/> SPUTUM PRODUCTION	<input type="checkbox"/> HEAT
<input type="checkbox"/> NOSE BLEEDS	<input type="checkbox"/> SNORING	<input type="checkbox"/> MUSCLE PAIN
<input type="checkbox"/> EAR OR HEARING PROBLEMS	<input type="checkbox"/> SHORT OF BREATH	<input type="checkbox"/> SWELLING
<input type="checkbox"/> HEADACHE	<input type="checkbox"/> WHEEZING	<input type="checkbox"/> DEPRESSION
<input type="checkbox"/> MIGRAINES	<input type="checkbox"/> BLOOD IN STOOL	<input type="checkbox"/> NERVOUSNESS
<input type="checkbox"/> EXCESSIVE THIRST OR APPETITE	<input type="checkbox"/> LOSS OF BOWEL CONTROL	<input type="checkbox"/> ANXIETY
<input type="checkbox"/> EXCESSIVE URINATION	<input type="checkbox"/> NAUSEA	<input type="checkbox"/> HALLUCINATIONS
<input type="checkbox"/> HEAT OR COLD INTOLERABLE	<input type="checkbox"/> VOMITING	<input type="checkbox"/> SKIN DISORDERS
<input type="checkbox"/> VISUAL DIFFICULTY	<input type="checkbox"/> ULCERS	<input type="checkbox"/> RASH
<input type="checkbox"/> REDNESS	<input type="checkbox"/> UROLOGICAL PROBLEMS	<input type="checkbox"/> POOR HEALING
<input type="checkbox"/> WATERY EYES	<input type="checkbox"/> PAINFUL URINATION	

The above information is true and correct to the best of my knowledge.

PATIENT SIGNATURE _____ DATE _____

M.D. REVIEW _____ DATE _____