Methodist PHYSICIANS | NEUROSURGICAL ASSOCIATES OF SAN ANTONIO

New Patient Health History Form

Neurosurgical Associates of San Antonio

PATIENT & CONTACT INFORMATION

Today's date ______ Last 4 of SSN ______

Name (Last, First) ______

Age ______ Date of birth ______

Phone Home ______ Work ______ Mobile ______

E-mail ______

REASON FOR VISIT

Brief summary of the reason for your visit *(3–5 words — not for MRI results)*

______

OTHER PHYSICIANS SEEN FOR THIS ISSUE

including your primary care manager (PCM)

Physician ______ Specialty ______

Physician ______ Specialty ______

INJURY & LEGAL

Is your condition related to an injury? ◯ Yes ◯ No Date of injury ______

Is a Workers' Compensation claim involved? ◯ Yes ◯ No

Is there litigation pending? ◯ Yes ◯ No

ABOUT YOU

Which hand do you write with? ◯ Right ◯ Left ◯ Both

Height ______ Current weight ______ Weight 1 yr ago ______

PATIENT NAME ______ DATE OF BIRTH ______

TREATMENTS TRIED FOR THIS CONDITION

check all that apply

Past pain medicines ______

- [ ] Chiropractic care
- [ ] Massage therapy
- [ ] Physical therapy
- [ ] Psychological counseling
- [ ] TENS unit
- [ ] Traction
- [ ] Acupuncture
- [ ] Pain management clinic
- [ ] Epidural steroid injection — # of injections ______
- [ ] Nerve block
- [ ] Facet block
- [ ] Other ______

For anything checked above — how many times, and when was the last time?

______

CHRONIC MEDICAL CONDITIONS

ever had, or currently have

- [ ] Heart attack — Date ______
- [ ] High blood pressure
- [ ] Cancer
- [ ] Infection — Type ______
- [ ] Stroke — Date ______
- [ ] Diabetes
- [ ] Blood clot / DVT
- [ ] Other ______

Any other medical conditions? Please list them below.

1. ______ **2.** ______

3. ______ **4.** ______

5. ______ **6.** ______

Methodist
PHYSICIANS | NEUROSURGICAL ASSOCIATES OF SAN ANTONIO

New Patient Health History Form

Neurosurgical Associates of San Antonio

PATIENT NAME ________ DATE OF BIRTH ________

PAST SURGERIES

brain or spine, and all other surgeries

Have you ever had brain or spine surgery? ◯ Yes ◯ No

SURGERY	DATE (MO/YR)	LOCATION / FACILITY	SURGEON

CURRENT MEDICATIONS

name and dosage

- ☐ See attached list
- ☐ Aspirin Dosage ________
- ☐ Coumadin / Warfarin
- ☐ Plavix / Clopidogrel
- ☐ Motrin / Ibuprofen

Other current medications (name & dosage)

________ ________

________ ________

Alternative & herbal medications ________

ALLERGIES

medicines or foods

- ☐ No known allergies

1. ________
2. ________

FAMILY HISTORY

diseases that run in your family

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ None known
- ☐ Other ________

PATIENT NAME ____ DATE OF BIRTH ____

SOCIAL HISTORY

TOBACCO

Ever used tobacco? ○ Yes ○ No **Type** ____

Packs per day ____ **Number of years** ____

Currently smoke? ○ Yes ○ No **If quit, what year?** ____

ALCOHOL

Drink alcohol? ○ Yes ○ No **Kind of alcohol** ____

How many drinks? ____ ○ per day ○ per week ○ per month

LIFESTYLE

Do you exercise? ○ Yes ○ No **How many times a week?** ____

Occupation ____ ☐ Disabled — since when? ____

Marital status ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Number of children ____ **Religious preference** ____ ☐ None

FALL RISK & IMMUNIZATIONS

Have you had a fall in the last year? ○ Yes ○ No **If yes, date** ____

Influenza (flu) vaccine? ○ Yes ○ No **When** ____

Pneumococcal (pneumonia) vaccine? ○ Yes ○ No **When** ____

Methodist
PHYSICIANS | NEUROSURGICAL ASSOCIATES OF SAN ANTONIO

New Patient Health History Form

Neurosurgical Associates of San Antonio

PATIENT NAME ______________________ DATE OF BIRTH ______________

REVIEW OF SYSTEMS

check any symptoms you are currently experiencing

General
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Recent weight change

Hematologic (Blood)
- ☐ Anemia
- ☐ Bleeding disorder

Eyes
- ☐ Changes in vision
- ☐ Double vision

Ear, Nose & Throat
- ☐ Hoarseness
- ☐ Throat pain
- ☐ Sinus infections
- ☐ Ear infections
- ☐ Hearing loss

Psychiatric (Mood)
- ☐ Anxiety
- ☐ Depression
- ☐ Poor sleep
- ☐ Suicidal thoughts

Cardiovascular (Heart)
- ☐ Chest pain
- ☐ Irregular heartbeat

Endocrine (Hormones)
- ☐ Excessive thirst
- ☐ Temperature intolerance
- ☐ Fatigue

Gastrointestinal
- ☐ Bowel incontinence
- ☐ Poor appetite
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal bleeding

Neurological
- ☐ Headache
- ☐ Dizziness
- ☐ Fainting spells
- ☐ Seizures
- ☐ Confusion
- ☐ Poor memory
- ☐ Speech difficulty
- ☐ Poor coordination
- ☐ Difficulty walking
- ☐ Balance problems
- ☐ Numbness
- ☐ Weakness
- ☐ Handwriting change

Respiratory (Lungs)
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough

Dermatologic (Skin)
- ☐ Rash
- ☐ Skin lesions

Genitourinary
- ☐ Loss of urinary control
- ☐ Frequent urination
- ☐ Urinary urgency
- ☐ Burning with urination
- ☐ Sexual dysfunction
- ☐ Possible pregnancy

Musculoskeletal
- ☐ Joint pain
- ☐ Groin pain / numbness
- ☐ Swelling / warmth

Infectious Disease
- ☐ HIV/AIDS exposure risk
- ☐ Tuberculosis exposure
- ☐ Hepatitis history
- ☐ Blood transfusion history

Methodist PHYSICIANS | NEUROSURGICAL ASSOCIATES OF SAN ANTONIO

New Patient Health History Form

Neurosurgical Associates of San Antonio

PATIENT NAME ____________ DATE OF BIRTH ____________

PAIN ASSESSMENT

complete only if evaluated for a painful condition

☐ *Not applicable — skip this section*

1. Where is the pain located? ____________ **Date it began** ____________

   Was there an initiating event? ◯ Yes ◯ No **Details** ____________

   Does the pain spread or radiate? ◯ Yes ◯ No **Where** ____________

2. Associated numbness or abnormal sensation? ◯ Yes ◯ No

   If yes, describe ____________

3. Associated weakness in any muscles? ◯ Yes ◯ No

   If yes, describe ____________

4. Rate your pain intensity *0 = no pain* *10 = worst pain imaginable*

	0	1	2	3	4	5	6	7	8	9	10
Worst pain	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Least pain	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Usual pain	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

5. How do these activities affect your pain?

	Better	Worse	No change
Lying down	◯	◯	◯
Sitting	◯	◯	◯
Standing	◯	◯	◯
Walking	◯	◯	◯
Coughing / sneezing	◯	◯	◯

6. Other factors that make the pain worse ____________
7. Other factors that make the pain better ____________
8. Days of work missed for this condition ____________ ☐ N/A
9. How has the pain interfered with your daily activities?

____

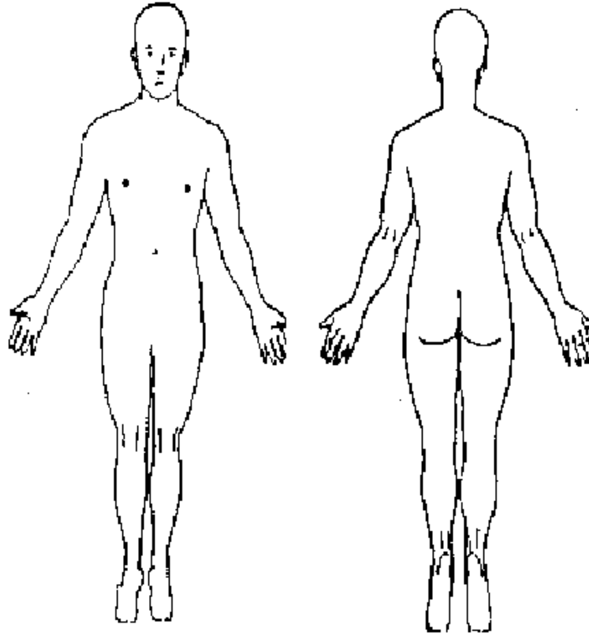
PATIENT NAME

DATE OF BIRTH

PAIN DIAGRAM

mark where and what type of pain you feel

Numbness	Pins / needles	Burning	Stabbing	Aching
- - - - -	o o o o o	x x x x x	/ / / / /	+ + + + +



Front (Right | Left) *Back (Left | Right)*

ACKNOWLEDGEMENT

Signature of patient

Date