PALM BEACH BRAIN & SPINE, LLC.

MICRONEUROSURGERY OF THE BRAIN & SPINE
MINIMALLY INVASIVE SPINAL SURGERY
STEREOTACTIC RADIATION THERAPY
NEUROSURGICAL ONCOLOGY
SKULL BASE SURGERY

PATIENT MEDICAL HISTORY

****All of the information requested is extremely important. We need complete and concise answers to** ALL of the questions in order to provide you with the safest and very best medical care.**

PERSONAL INFORMATION

Date: ___________________

Patient Name____
Last First Middle

Address____
Street City State Zip Code

Home Phone: (______)_________________________ Cell Phone: (_____)_________________________

Date of Birth: ______/_______/______ Gender: M or F Age: _______ SSN# ___________________________

Occupation: ___________________ Employer _________________________ Work Phone # _________________

Emergency Contact and Phone #:____

Family Physician/Internist _________________________________ Phone #(_____)_________________________

Referring Physician ______________________________________ Phone #(_____)_________________________

Attorney Name ____ Phone # (_____)_________________________

INSURANCE INFORMATION

Primary Insurance ______________________________ ID#_______________________ Group#_____________

Address ____

Insured Name ____________________________________ Relationship to Insured __________________________

Secondary Insurance ________________________________ ID# ____

Address____

Group #___________________ Insured Name ______________________________Relationship ______________

Auto/Workers Comp Insurance_________________________________Claim#___________________________

Address ____

Date of Injury/Accident ____________________ Type of Injury ☐ Auto ☐ Workers Compensation

Adjusters Name _______________________________________Phone # (______) ___________________________

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MEDICAL INFORMATION

Reason for your visit today? ____

How long have you had this problem? ____

Were you injured in an accident? [ ] Yes [ ] No If yes check one: [ ] Motor Vehicle Accident

[ ] Worker's Comp Accident [ ] other ____

Have you had any other prior injuries? [ ] Yes [ ] No If yes, please list: ___________________________

____

MEDICAL INFORMATION CON'T:

Have you had same or similar symptoms in the past? [ ] Yes [ ] No If yes, please describe:

____

Have you had any of the following treatment(s) for your current symptoms?

	No	**Yes**	**Length of treatment**	**Treatment Provider**
Traction	___	___	________________	______________________
Chiropractic Manipulation	___	___	________________	______________________
Physical Therapy	___	___	________________	______________________
Massage	___	___	________________	______________________
Exercise Therapy	___	___	________________	______________________
Trigger Point Injections	___	___	________________	______________________
Acupuncture	___	___	________________	______________________
Epidural Steroid Injections	___	___	________________	______________________

Height _______ Weight _______ Are you Claustrophobic? [ ] Yes [ ] No

PAST MEDICAL HISTORY:

Any metal in your body? (Pacemaker, aneurysm clips, rods, screws, pins shrapnel etc.) [ ] Yes [ ] No

If yes, explain: ____

Have you ever been treated for:

	No	**Yes**		**No**	**Yes**
Anemia	___	___	Bleeding Disorder	___	___
High Blood Pressure	___	___	Heart Attack	___	___
Ulcer	___	___	HIV/AIDS	___	___
Cancer	___	___	Asthma and/or Emphysema	___	___
MRSA	___	___	Liver Problems	___	___
Epilepsy	___	___	Kidney Problems	___	___
Stroke	___	___	Heart Disease/Angina	___	___
Diabetes	___	___	Alcohol or Drug Abuse	___	___

Please list any other serious medical conditions not on the above list: _____________________________

____

ALLERGIES: Please list any medication or other allergies that you might have.

____

____

Latex Allergy: ________ YES ________ NO

PREVIOUS SURGERY: Please list **ALL** operations you have had.

Type of surgery	Month/Year	Surgeon	City
____________________	_____________	___________________	________________
____________________	_____________	___________________	________________
____________________	_____________	___________________	________________
____________________	_____________	___________________	________________

CURRENT MEDICATIONS: Please take the time to completely and accurately list **ALL** of the medications you currently take, including aspirin, vitamins and other supplements. (You may attach a medication list.)

Name of medication	Dosage	How often	Taken for:
________________________	___________	_____________	____________________
________________________	___________	_____________	____________________
________________________	___________	_____________	____________________
________________________	___________	_____________	____________________
________________________	___________	_____________	____________________

FAMILY HISTORY: Please list any serious illnesses that have occurred in your family.

Cancer Yes [ ] No [ ] Relation____

Heart Disease Yes [ ] No [ ] Relation____

Stroke Yes [ ] No [ ] Relation____

Diabetes Yes [ ] No [ ] Relation____

Aneurysm Yes [ ] No [ ] Relation____

Brain Tumor Yes [ ] No [ ] Relation____

Other Neurological or Muscular Diseases
Yes [ ] No [ ] Relation____

Other serious illnesses
Yes [ ] No [ ] Relation____

SOCIAL HISTORY:

Married? Yes [ ] No [ ] Spouse's name and phone # ____

Is there a family member or friend living with or near you who would be available to assist you once you've been discharged from the hospital, should the need arise? Yes [ ] No [ ]
Name/Phone ____

Do you smoke? Yes [ ] No [ ] How many packs per day? ______________________________________

If yes, how old were you when you started? ______ How old were you when you stopped? _________

Do you drink alcohol? Yes [ ] No [ ] If yes, in an average week, how many drinks do you consume? ____

Do you use any recreational or illegal drugs? Yes [ ] No [ ] If yes, please specify: ___________________

Patients Name: ____ D.O.B: ________________

REVIEW OF SYSTEMS:

Do you currently, or have you had problems with: (Circle yes or no)

Constitutional

Fever…………………….. Yes No
Weight Loss……………Yes No
Excess Fatigue…………Yes No
Night Sweats…..............Yes No

Eyes

Wear Glasses…………...Yes No
Date of last exam: __________
Infections………………Yes No
Injuries…………………Yes No
Glaucoma………………Yes No
Cataracts………………..Yes No

Ear, Nose, Throat and Mouth

Wear hearing aids………Yes No
Date of last exam: __________
Hearing Loss……………Yes No
Ear Infections…………..Yes No
Ringing in Ears…………Yes No
Left Right Both
Balance Disturbance……Yes No
(i.e. Vertigo, spinning)
Nosebleeds……………..Yes No
Nasal Congestion……….Yes No
Nasal Drainage…………Yes No
Inability to smell………..Yes No
Sinus Problems…………Yes No
Sore Throats……………Yes No
Mouth Sores……………Yes No

Cardiovascular

Chest Pain or Angina…..Yes No
Date of last EKG: ___________
High Blood Pressure……Yes No
Irregular Pulse…………..Yes No
Heart Murmur…………...Yes No
High Cholesterol………...Yes No
Swelling of feet/hands…..Yes No
Leg pain while walking…Yes No

Respiratory

Asthma…………………Yes No
Chronic Cough…………Yes No
Emphysema……………..Yes No
Shortness of breath……...Yes No
Bronchitis………………Yes No
Pneumonia………………Yes No
Lung Cancer…………….Yes No
Bloody Sputum…………Yes No
Date of last chest x-ray: __________

Gastrointestinal

Indigestion or Pain with eating…....Yes No
Nausea…………………………...Yes No
Blood in your vomit………………..Yes No
Liver Disease………………………Yes No
Jaundice……………………………Yes No
Abdominal Pain……………………Yes No
Change in Bowel Habits……………Yes No
Ulcer or Gastritis……………………Yes No

Genitourinary

Urinary Tract Infections……………Yes No
Painful urination……………………Yes No
Blood in your urine…………………Yes No
Incontinence………………………..Yes No
Kidney Stones………………………Yes No
Prostate Cancer (Males)…………….Yes No
Endometriosis (Females)…………...Yes No
Uterine or Cervical Cancer…………Yes No

Musculoskeletal

Broken bones………………………Yes No
List: _______________________________
Neck pain……..……………………Yes No
Arm pain ……………….………….Yes No
Arm weakness ……….……………Yes No
Leg pain …………………………... Yes No
Leg weakness………………………Yes No
Back pain…………………………...Yes No
Joint pain or swelling………………Yes No
Arm numbness/tingling……………..Yes No
Leg numbness/tingling……………...Yes No

Integumentary

Skin Disease………………………...Yes No
Skin Cancer…………………………Yes No
Breast pain, tenderness or swelling
(Females)…………Yes No
Nipple discharge (Females)…………Yes No
Date and result of last Mammogram:
(Females) _____________________________

Neurological

Fainting spells or "Blacking Out"…..Yes No
Seizures……………………………..Yes No
Memory Problems…………………..Yes No
Disorientation………………………Yes No
Difficulty with speech………………Yes No
Headache……………………………Yes No
Double or blurred vision……………Yes No
Face weakness………………………Yes No
Coordination in arms………………..Yes No
Coordination in legs…… …………..Yes No

Psychiatric

Anxiety……………………………...Yes No
Depression…………………………..Yes No
Other Psychiatric disorder/treatment.Yes No
If yes, please explain: _________________

Patients Name: ____ **D.O.B:** __________

REVIEW OF SYSTEMS CON'T:

Endocrine

Diabetes……………………….Yes No
Thyroid Disease………………Yes No
Increased appetite….…………Yes No
Excessive thirst or urination…..Yes No
Hormone Problems……………Yes No

Hematologic/Lymphatic

Anemia………………………..Yes No
Hemophilia……………………Yes No
Bleeding Tendencies………….Yes No
Persistent Swollen Glands
or Lymph Nodes……………Yes No
Blood Transfusion……………Yes No
If yes, when? _____________________

Allergic/Immunologic

Food Allergies………………..Yes No
Inhalant (nasal) Allergies…….Yes No
Immunologic Disorders………Yes No

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

____
Patient Signature **Date**

I have reviewed the above information with the patient.

____
Physician Signature **Date**

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