SOUTH FLORIDA NEUROSURGERY

NEW PATIENT FORM

DATE: _____

FIRST NAME: _____M:_____LAST: _____

ADDRESS:_____CITY/STATE_____ZIP_____

TEL #: _____ CELL#: _____ LANGUAGE:_____
DOB:_____ SEX: M / F S.S. # :_____ MARTIAL: S / M / D / W

EMAIL ADDRESS: _____

OCCUPATION:_____EMPLOYER:_____WORK #:_____
Referring Doctor: Primary Care Physician:
_____ _____

Describe briefly your present symptoms: _____

When did this problem first start?

_____

Are you Right OR Left Handed?_____

Medication Allergies: _____
_____
Food Allergies: _____
_____
Drug Allergies: _____

Are you Allergic to contrast dye?

CURRENT MEDICATIONS

Are you on any blood thinners: ❑ No ❑ Yes
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements. **How long have you been taking this?**

Name of drug:	**Dose (include strength & number of pills per day)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	

PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Coronary Artery Disease ❑

❑ Diabetes	❑ Stroke ❑ (TIA)	❑ Hepatitis
❑ High blood pressure	❑ Epilepsy (seizures)	❑ Stomach or peptic ulcer
❑ High cholesterol	❑ Cataracts	❑ Rheumatic fever
❑ Cancer (type) _____	❑ Kidney disease	❑ Tuberculosis
❑ Heart murmur	❑ Kidney stones	❑ HIV/AIDS
❑ Pneumonia	❑ Crohn's disease	
❑ Pulmonary embolism	❑ Colitis	
❑ Asthma	❑ Anemia	
❑ Emphysema	❑ Jaundice	

Other medical conditions (please list): **List Surgeries/ Dates:**

_____ _____

_____ _____

_____ _____

MRI (location and date):

_____

CT Scan/X-rays (location and date):_____

Your blood relatives have had the following:

Cancer: _____

Heart Disease: _____

Stroke:_____

Diabetes: _____

PERSONAL HISTORY

Past Surgeries and dates: _____

Previous treatment Brain or Spine dates:_____

Injections/epidurals/cortisone shots to the area/dates: _____

Physical therapy dates: _____

Do you have any Metal or Implants in your body?_____

SOCIAL HISTORY:

Do you smoke? _____ How many packs a day? _____

Do you drink? _____ How much and how often? _____

IV Drug user: _____ Please Explain: _____

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?_____

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

_____
_____
_____
_____
_____
_____
_____
_____
_____