Pacific Neurosurgery
45 Castro Street, Suite 421
San Francisco, CA 94114

PATIENT INFORMATION AND MEDICAL HISTORY		
Last Name	First Name	DOB

Current Medications & Dosage (mg): _____

_____

Allergies (Drug and/or Medical): _____

_____

Previous Surgical Procedures & Approx. Date: _____

_____

Previous Significant Injuries & Approx. Date: _____

_____

PERSONAL HISTORY
Do You Drink Alcohol: □ Yes □ No □ Occasionally
Do You Smoke: □ Yes □ No □ I did smoke, but I do not smoke currently *If yes, do you smoke: □ Everyday □ Occassionally*

MEDICAL HISTORY

Do you experience any of the following:

□ Back Pain	□ STD	□ High Blood	□ Kidney Problems	□ Arthritis
□ Neck Stiffness	□ Blood Clots	□ Irregular Pulse	□ Hepatitis/Jaundice	□ Stroke
□ Heart Problems	□ Thyroid Problems	□ Chest Pain/Angina	□ Heartburn	□ HIV Positive/Risk
□ Asthma	□ Numbness or	□ Ulcers	□ Transfusions	
□ Cancer/Malignancy	□ Seizure/Epilepsy	□ Bleeding Problems	□ Anemia	
□ Alcohol/Drug	□ Tuberculosis	□ Diabetes	□ Difficulty Urinating	

Explanation of above/ other medical problems: _____

_____

REVIEW OF SYSTEMS

Below, please indicate any symptoms you are currently experiencing (within the last month):

General, Constitutional	☐ Good general health lately	☐ Fever	☐ Fatigue
	☐ Recent weight change		
Musculoskeletal	☐ Joint Stiffness and Swelling	☐ Weakness of muscles/joints	☐ Cold extremities
	☐ Muscle pain or cramps	☐ Lower back pain	
	☐ Neck pain	☐ Difficulty walking	
Psychiatric	☐ Nervousness	☐ Depression	☐ Sleep problems
	☐ Anxiety or panic attacks		
Ears, Nose & Throat	☐ Ringing in the Ears	☐ Nose bleeds	☐ Swollen glands in neck
	☐ Ear aches/drainage	☐ Hearing loss	☐ Mouth sores
	☐ Sinus Problems	☐ Sore throat/voice change	
Neurological	☐ Stroke	☐ Paralysis	☐ Memory Loss or confusion
	☐ Head Injury	☐ Light headed/dizzy	☐ Migraines
	☐ Numbness / tingling	☐ Convulsions / seizures	☐ Frequent / recurrent headaches
Heart & Cardiovascular	☐ Chest pain	☐ Sudden heartbeat changes	☐ Swelling of feeat, ankles, hands
Respiratory	☐ Spitting up blood	☐ Shortness of breath	☐ Asthma Weezing
	☐ Frequent coughing		
Eyes & Vision	☐ Wear glasses or contact lenses	☐ Blurred or double vision	☐ Glaucoma
	☐ Eye diseases or injury		
Gastrointestinal	☐ Change in bowel movements	☐ Nausea or vomiting	☐ Frequent diarrhea
	☐ Painful bowel movements	☐ Constipation	☐ Loss of appetite
	☐ Stomach pain	☐ Blood in stool	
Genitourinary	☐ Sexual difficulty	☐ Kidney stones	☐ Burning or painful urination
	☐ Blood in urine	☐ Strain with Urination	☐ Incontinence or dribbling
	☐ Frequent urination		
Endocrine	☐ Thyroid disease	☐ Diabetes	☐ Excessive thirst or urination
	☐ Heat or cold intolerance	☐ Glandular or hormone problem	☐ Rash or itching
	☐ Change in skin color		
Skin & Breasts	☐ Varicose veins	☐ Breast pain	☐ Breast lump
	☐ Breast discharge	☐ Change in hair or nails	☐ Dry skin
Hematologic/Lymphatic	☐ Easily bruise or bleed	☐ Anemia	☐ Phlebitis
	☐ Transfusion	☐ Slow to heal after cuts	☐ Swollen glands

Other: _____

_____

FAMILY HISTORY

	Living or Deceased	Healthy?	Cause of Illness
Father			
Mother			
Children			

Has any blood relative…

			If yes, please indicate who:
Had Cancer?	Yes /	No	
Had early heart disease?	Yes /	No	
Is or has been an alcoholic?	Yes /	No	
Is or has been a drug addict?	Yes /	No	
Had unusual bleeding tendencies?	Yes /	No	

Signature	Date