

MCW Department of Neurosurgery

Initial Visit Information Date form completed: _____

Prior to your scheduled clinic visit, please take a moment to answer each question and complete all areas that apply to your health. This information will be reviewed by the physician and will be useful in the evaluation and treatment of your condition.

Name: _____ Date of Birth _____ Age: _____ Sex: M / F

Phone Number: _____ Handedness: Right / Left / Both

Primary Care Physician: _____ Referring Physician: _____

Additional Physicians: _____

Reason for visit (Type/Onset/Duration/Severity of symptoms):

Past Medical History:

Major Illnesses:	Surgeries/Hospitalizations: (month / year)	Surgeon
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____
5. _____	5. _____	5. _____
6. _____	6. _____	6. _____

Have you ever had a major injury? Yes / No If yes, please describe:

Do you have a disability? Yes / No If yes, please describe:

Immunizations up to date (circle one): Yes / No

Allergies: Yes / No Identify reaction to allergy:

Medications:

Medication	Dosage	How many per day	Date started	Prescribing Physician

List additional medications on back of form.

Social History:

Marital History: Single / Married / Divorced / Widowed	Number of children: 1 / 2 / 3 / 4 / 5 / 6 / ____
Educational Level: Elementary / High School graduate / College – Degree ____	
Occupation: _____ Employer: _____ Years employed at present job _____	
Have you lost any work time related to current symptoms? Yes / No	
Have you missed work due to your condition? Yes / No How much time have you missed work? _____	
Do you use tobacco products: Yes / No Type: _____	
Amount: _____ How many years have you used tobacco products? _____	
Have you smoked in the past? Yes / No Number of years smoked: _____ Year quit: _____	
Do you drink Alcohol? Yes / No Type and number of drinks per week: _____	
Do you have a history of alcohol abuse? Yes / No	
Have you ever had treatment to stop drinking? Yes / No Date: _____	
Do you use or have you ever-used Street Drugs? Yes / No Type: _____ How often: _____	
Present Weight: _____ Height: _____ Do you exercise? Yes / No	
Describe type and frequency: _____	
Do you have a special diet? _____	
Do you have any hobbies? If yes, please describe:	

Family Health History:

Do medical problems run in your family? Yes / No
If yes, please list family member(s) and medical problem(s):

Review of Systems

Please write number where appropriate. 1 – PRESENTLY HAVE 2 – HAVE HAD IN THE PAST YEAR

GENERAL

- Allergy
- Chills
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Sweats
- Sleep loss
- Weight gain
- Weight loss
- Tremors
- Nervousness
- Mental disorder

EARS, EYES, NOSE & THROAT

- Asthma
- Colds
- Hoarseness
- Sinus infection
- Sinus headaches
- Sore throat
- Swallowing difficulties
- Earaches
- Hearing loss
- Ringing in the ears
- Visual changes
- Blurred Vision
- Double Vision
- Loss of peripheral vision

RESPIRATORY

- Shortness of breath
- Wheezing
- Chronic cough
- History of bronchitis
- History of pneumonia
- Spitting up blood
- History of asthma
 - Exercise induced
 - Allergy induced
- Lung Cancer
- Tuberculosis

For office use only

MUSCULOSKELETAL

- Arthritis – location: _____
- Poor posture
- Numbness/Tingling/Pain:
 - Neck
 - Shoulders
 - Arms
 - Elbows
 - Hands
 - Hips
 - Legs
 - Knees
 - Feet
 - Low back

NEUROLOGICAL

- Weakness – Location: _____
- Memory problems
- Personality changes
- Balance difficulties
 - Upon rising
 - Feeling of movement/ spinning
 - Constant
- Seizures
 - Warning before seizure
- Epilepsy disease
- Headaches – location: _____
 - Upon rising in the morning
 - Worsen with activity
- Dizziness
- History of stroke

SKIN

- Rash
- Hair loss
- Lumps in breast
- Skin cancer

HEMATOLOGY

- Anemia
- Bruise easily
- Bleeding tendencies

GENITOURINARY

- Blood in urine
- Frequent urination
- Loss of bladder control
- Difficult to urinate
- Painful urination
- Frequent nighttime urination
- Bladder or kidney infection
- Kidney stones
- Lack of menstrual cycle (females)
- Irregular menstrual cycle (females)
- Endometriosis (females)
- Uterine/cervical cancer (females)
- Unable to maintain erection (males)
- Prostate problems (males)
- Prostate cancer (males)

GASTROINTESTINAL

- Belching or gas
- Constipation
- Diarrhea
- Distention of stomach
- Excessive hunger
- Poor appetite
- Nausea/vomiting
- Gallbladder problems
- Liver problems
- Liver disease
- Alcoholism
- Colon cancer

CARDIOVASCULAR

- High blood pressure
- Low blood pressure
- Hardening of the arteries
- Chest pain or angina
- Heart attack – date: _____
- Rapid heart rate
- Slow heart rate
- Palpitations of the heart
- Poor circulation
- Swelling of ankles
- Heart disease
- High cholesterol

ENDOCRINE

- Heat or cold intolerance
- History of thyroid disease
- History of diabetes

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

Patient signature _____

Date _____

FOR NECK OR BACK PROBLEMS PLEASE COMPLETE ADDITIONAL PAGES 4-6

Does your job involve lifting? Yes / No **Maximum lifting weight:** _____

Have you ever considered changing your job because of your spine problem? Yes / No

Regarding current symptoms, do you have a worker's compensation or personal injury claim? Yes / No

Name of Attorney handling your claim (if appropriate): _____

Have you had a worker's compensation or previous injury claim at any time for prior problems? Yes / No

Please describe claim(s):

Describe current injury or accident & date it occurred:

STRENGTH

Do you have weakness? Yes / No

Location and description:

Do you have to stop walking due to weakness? Yes / No

Do you have lack of bowel or bladder control? Yes / No

Do you have decrease in sexual function? Yes / No

SENSATION

Do you have loss of feeling or sensation? Yes / No

Location and description:

Do you have difficulty walking due to loss of feeling/sensation? Yes / No

PAIN REVIEW

Do you presently have pain? Yes / No

Location and description:

Does the pain wake you from sleep? Yes / No

Do you have difficulty walking or have to stop walking due to pain? Yes / No

Factors that effect my pain: (check appropriate line)

	Better	Worse	No Different
1) With cough or sneeze	_____	_____	_____
2) Sitting	_____	_____	_____
3) Bending forward, as in brushing teeth	_____	_____	_____
4) Walking	_____	_____	_____
5) Prolonged Standing	_____	_____	_____
6) Lying flat on back	_____	_____	_____
7) Lying flat on stomach	_____	_____	_____
8) Lying on side with knees bent	_____	_____	_____
9) Lifting, reaching, or twisting	_____	_____	_____
10) Other (list) _____	_____	_____	_____

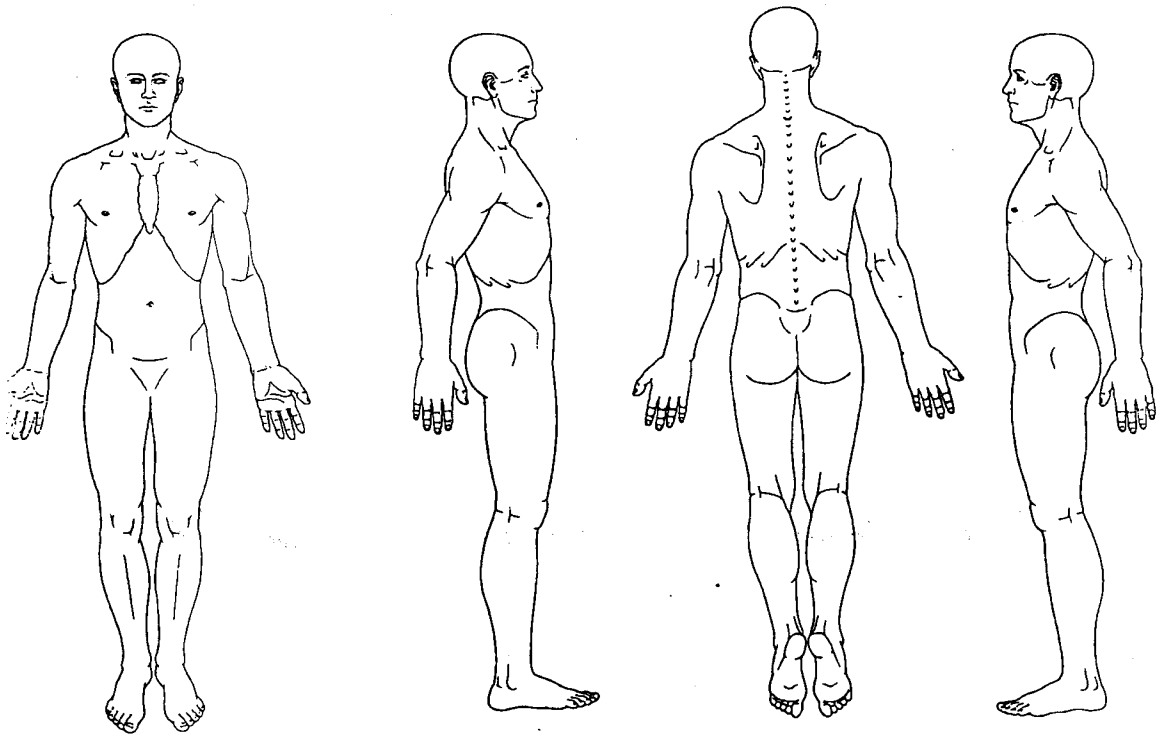
Using the identified codes, indicate nature, location & direction of your pain on the drawing:

Sharp/Stabbing pain ^^^^

Dull aching pain XXX

Burning Pain ::::

Numbness/Tingling NNNN



Location and severity of pain:

Circle range of pain severity during the past week: 0 = no pain; 10 = severe pain for each region of the body you identified.

Document "x" on usual level of pain for the region of the body you identified.

Region of the body:

Pain levels:

_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10

Check prior treatments and indicate results: (B = better; W = worse; NC = no change)

Chiropractic medicine _____ **Rehabilitation Specialist** _____

Pain Management Specialist _____ **Acupuncturist** _____

Physical Therapy:

TENS _____ Ultrasound _____ Whirlpool _____ Traction _____

Massage _____ Diathermy _____ Exercise _____

Steroid injections: Yes / No

Date of injection **Location/body region of injection** **Duration of response**

_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous testing	Location/hospital performed	Date	Results (if known)
Plain X-rays	_____	_____	_____
MRI	_____	_____	_____
CT Scan	_____	_____	_____
Myelogram	_____	_____	_____
EMG/NCS	_____	_____	_____
Discography	_____	_____	_____

Other:

I have reviewed the above information with the patient.

Physician review: _____

Date: _____

Physician review: _____

Date: _____

Physician review: _____

Date: _____

Revised 10/28/04 /bb