Neurological Surgery and Spine Surgery Medical History Form

Name:____________________________
Date:_________________ Age:___
Referring doctor:_____________________
Height:_______ Weight: ______

Are you right handed or left handed? ____

Please describe your symptoms:

When did your symptoms begin?

What position makes your symptoms worse?
Sitting, standing, lying down (circle one)

What position makes your symptoms worse?
Sitting, standing, lying down (circle one)

What else makes your symptoms better?

What else makes your symptoms worse?

How long can you sit?
How long can you stand?
How far can you walk?

Past Medical History (List all medical problems):

Past Surgical History (List all operations):

Allergies:

Current Medications (Please list or attach):

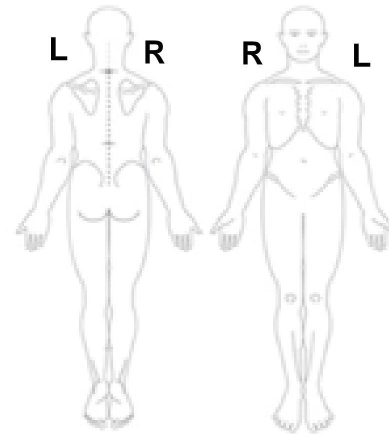
Do you smoke? Yes No
How much do you smoke?

How much alcohol do you drink per week?

With whom do you live?

Are your parents and siblings alive? List any medical problems:

Father:
Mother:
Siblings:



Pain diagram:

Please draw **xxx** where you have pain

Pain Severity on scale of 0-10 **(Circle One)**
0 1 2 3 4 5 6 7 8 9 10

Review of Systems (Circle all that apply):

fever, chills, weight loss, weight gain, joint pain, weakness, numbness, decreased range of motion, tingling in arms or legs, constipation, inability to control stool or urine, depression anxiety, difficulty sleeping, chest pain, shortness of breath

Other symptoms:

Work History:
Place of Employment:

Job Description:

Circle which applies:
- Heavy Duty (50-100 pounds)
- Medium duty (20-50 pounds)
- Light duty (up to 20 pounds)
- Desk work (less than 10 pounds)

Prior Treatments (Circle all that apply):

Bed Rest: No relief, some relief, good relief
Physical therapy: No relief, some relief, good relief
Chiropractic: No relief, some relief, good relief
Cortisone injections: No relief, some relief, good relief
Brace: No relief, some relief, good relief