# Mercy Clinic Neurosurgery
# Cranial Health History Form

Please fill out this form completely and **MAIL/EMAIL/FAX IT BACK 2 DAYS PRIOR TO YOUR VISIT** so that we can learn about you and best decide how to treat your condition. Additionally, please bring your insurance card, driver's license or identification card, CD of your prior imaging, and previous reports of any neurological or neurosurgical testing or consultations to your visit.

Name _____ DOB_____ Age _____

Address _____

Email _____

Phone # (H) _____ (W) _____ (C) _____

Emergency Contact: _____ Phone #: _____

Referring Physician: Primary Physician: ☐ same as referring physician

Name _____ Name _____

Phone #: _____ Phone #: _____

Specialty _____

Please list any other physicians you would like us to notify:

_____

Preferred Pharmacy: _____ Phone#: _____

## History of Present Illness

Chief Complaint (the one **main** problem/symptom for seeing us today)

_____

Where is your problem? What body parts are affected? Please be specific.

_____

_____

_____

How long ago did your problem begin? _____

Did this result from an injury (please describe if so)? _____

Is it constant, or does it "come and go"? _____

How severe is your problem/symptom today? (please circle) mild moderate severe

If you have pain, how severe is it from 0 (no pain) to 10 (worst imaginable)? _____

If pain/sensory abnormality, how would you describe it? (Circle any that apply)

Aching Dull Sharp Throbbing Shooting Pressure Burning Pins/needles Tingling

_____

What circumstances, activities or positions **worsen** your problem/symptoms?

_____

What circumstances, activities or positions **lessen** (even temporarily) your problem/symptoms?

_____

Do you have any other symptoms that may be related to your main problem?
(Examples: Vision loss, imbalance, hearing loss, headaches, nausea, troubles with speech or memory, difficulty swallowing, weakness, numbness, etc…)

_____

_____

_____

Are you: ☐Right Handed ☐Left Handed ☐Ambidextrous

**Cancer History**

Have you been diagnosed with cancer in the past?

☐Yes ☐No (you may skip to the next section)

What is the name of your Oncologist: _____

What type(s) of cancer do/did you have? Date of Diagnosis

_____ _____

_____ _____

_____ _____

What treatments have you received:

☐Surgery ☐Chemotherapy ☐Immunotherapy ☐Radiation

Are you in remission? Yes No Date of remission _____

Please use the space below to elaborate if necessary:

_____

_____

**Medical problems**. Have you ever been diagnosed with, treated by a physician, or taken medications for any of the following medical conditions?

| Past Medical History | Y | N | | Y | N |
|---|---|---|---|---|---|
| Anemia | | | Autoimmune Disease _____ | | |
| Bleeding/Clotting Disorder | | | Rheumatoid Arthritis | | |
| DVT/PE | | | Dementia / Alzheimer's Disease | | |
| Chronic Steroid Use | | | Parkinson's Disease | | |
| High Cholesterol | | | Anxiety/Depression | | |
| Hypertension | | | Bipolar/Schizophrenia/Psychosis | | |
| Diabetes ☐Adult ☐Juvenile | | | Chronic Headaches / Migraines | | |
| Arrythmia / Atrial Fibrillation | | | Convulsions (seizures) | | |
| Heart Attack | | | TIAs / Strokes | | |
| Heart Disease | | | Narrowing of Carotid Arteries | | |
| Congestive Heart Failure | | | Brain Bleed | | |
| Heart Valve Problems | | | Aneurysm | | |
| COPD | | | Vascular malformation of brain | | |
| Sleep Apnea | | | Brain Tumor | | |
| Thyroid Disorder | | | Skin disorder | | |
| Tuberculosis | | | Polycystic Kidney Disease | | |
| HIV or AIDS | | | Prostate Disease | | |
| Hepatitis ☐B or ☐C | | | Gastro-intestinal bleeding | | |
| Depressed Immune System | | | Gastric Reflux | | |
| Major Infection _____ | | | Scoliosis | | |

Females: Are you now pregnant? ☐ Yes ☐ No

Please use this space to elaborate on any of the above or include other diagnoses if needed:

_____

_____

| Past Surgical History (PSHx) | | |
|---|---|---|
| **Cranial Procedures (Craniotomy, shunts, radiosurgery, etc...)** | **Surgeon** | **Date** |
| | | |
| | | |
| | | |
| | | |

Any complications from the procedures listed above?

_____

| Past Surgical History (PSHx) | |
|---|---|
| **Other Surgeries** | **Date** |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Have you had any problems with anesthesia in the past? ☐ Yes ☐ No
If yes, please explain:

_____

| Family Medical History (FMHx) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Children | Mother | Father | Brother | Sister | Grandmother (maternal) | Grandmother (paternal) | Grandfather (maternal) | Grandfather (paternal) | Aunt | Uncle |
| Diabetes | | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | | |
| Heart Disease | | | | | | | | | | | |
| Tobacco Use | | | | | | | | | | | |
| Blood Clots | | | | | | | | | | | |
| Brain Aneurysms | | | | | | | | | | | |
| Arteriovenous Malformations (AVMs, cavernomas) | | | | | | | | | | | |
| Brain Tumor | | | | | | | | | | | |
| Cancer | | | | | | | | | | | |
| Neurofibromatosis Type 1 or 2 | | | | | | | | | | | |
| | | | | | | | | | | | |

| Social History (SHx) | |
|---|---|
| Alcohol Use | Never Current Former Date Quit |
| Tobacco Use | Never Current Former Date Quit |
| | Average packs per day? Chewing tobacco? Yes No |
| Drug Use | Yes No Type: |
| Occupation | Retired? Unemployed? |
| Disabled? | Yes No Reason: Date: |
| Marital Status | Married Divorced Single Widowed |

| **Medications (Please include over the counter meds – attach list if necessary)** | | | |
|---|---|---|---|
| Drug | Dosage | Frequency & Length of Time | Reason |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| **Allergies** | **Reaction** |
|---|---|
| Medications? No Yes (please list below): | |
| Latex? No Yes (please describe): | |
| Iodine? No Yes (please describe): | |
| Metals? No Yes (please describe): | |
| Foods? No Yes (please describe): | |

## Review of Systems

Please check any of the medical condition(s) below which apply to you. If none, check here: ☐

**Constitutional**
☐Change in appetite
☐Excessive sleepiness
☐Fatigue
☐Fever/Chills
☐Night Sweats
☐Recent sore throat
☐Unexpected weight loss

**Eyes**
☐Light Sensitivity
☐Blurred vision
☐Double vision
☐Peripheral vision loss
☐Visual impairment
☐Macular degeneration
☐Cataracts
☐Glaucoma

**Ears, Nose, & Throat**
☐Hearing loss
☐Clear drainage for ears
☐Clear drainage for nose
☐Ringing in ears
☐Sinus disease
☐Trouble swallowing

**Cardiovascular**
☐Chest pain/pressure
☐Fainting
☐Heart defect
☐Heart murmur
☐High blood pressure
☐Low blood pressure
☐Leg Swelling
☐Palpitations

**Respiratory**
☐Bronchitis
☐Chronic cough
☐COPD
☐Emphysema
☐Pneumonia
☐Shortness of breath
☐Trouble breathing
☐Wheezing

**Gastrointestinal**
☐Nausea
☐Vomiting
☐Black or bloody stool
☐Constipation
☐Diarrhea
☐Heartburn
☐Ulcer
☐Loss of control

**Skin**
☐Birth marks
☐Psoriasis
☐Skin rashes
☐Melanoma
☐Abnormal stretch marks

**Endocrine**
☐Dry eyes/mouth
☐Endocrine disorder
☐Low blood sugar
☐Pituitary disorder
☐Sickle cell disease
☐Abnormal cycles
☐Leaking from breasts
☐Easy bruising/bleeding

**Genitourinary**
☐Blood in urine
☐Change in habits
☐Recurrent infection
☐Kidney stones
☐Loss of control
☐Painful urination
☐Urinary urgency

**Musculoskeletal**
☐Connective tissue
☐disorder
☐Low back pain
☐Neck pain
☐Joint pain
☐Joint replacement
☐Joint swelling
☐Lymph node swelling
☐Muscle aches

**Neurological**
☐Altered taste/smell
☐Balance difficulty
☐Clumsiness
☐Concussion
☐Confusion
☐Concentration difficulty
☐Dizziness
☐Falls
☐Facial pain
☐Hallucinations
☐Headache
☐Loss of consciousness
☐Memory problems
☐Muscle twitching
☐Nausea
☐Numbness
☐Personality change
☐Shooting pains
☐Speech difficulty
☐Tingling sensation
☐Tremors
☐Vertigo
☐Walking difficulty
☐Weakness

**Psychological**
☐Substance abuse
☐Suicidal thought