

Mercy Clinic Neurosurgery Spine 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 percentage of pain is in your neck and what percentage is in your arm(s)?

_____ %Neck _____ %Arm(s)

What percentage is in your back and what percentage is in your leg(s)?

_____ %Back _____ %Leg(s)

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

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

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			Gout		
Cancer – Type? _____			Rheumatoid Arthritis		
Chronic Steroid Use			Osteoarthritis		
High Cholesterol			Osteoporosis or osteopenia, T-score____		
Hypertension			Bone or connective tissue disease		
Diabetes <input type="checkbox"/> Adult <input type="checkbox"/> Juvenile			Scoliosis		
Arrhythmia / Atrial Fibrillation			Anxiety/Depression		
Heart Attack			Bipolar/Schizophrenia/Psychosis		
Heart Disease			Chronic Headaches / Migraines		
Congestive Heart Failure			Convulsions (seizures)		
Heart Valve Problems			Stroke		
COPD			Brain Disease _____		
Sleep Apnea			Thyroid Disorder		
Asthma			DVT/PE _____		
Tuberculosis			Skin disorder		
HIV or AIDS			Kidney Disease		
Hepatitis <input type="checkbox"/> B or <input type="checkbox"/> C			Prostate Disease		
Depressed Immune System			Gastro-intestinal bleeding		
Major Infection _____			Gastric reflux (GERD)		

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)		
Spine Surgeries	Surgeon	Date

Any complications from any of 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)										
	Mother	Father	Brother	Sister	Grandmother (maternal)	Grandmother (paternal)	Grandfather (maternal)	Grandfather (paternal)	Aunt	Uncle
Brain Aneurysm										
Cancer-- <i>Type?</i>										
Diabetes										
High Cholesterol										
High Blood Pressure/ Hypertension										
Heart Disease										
Tobacco Use										
Spinal Stenosis										
Blood Clots										

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

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 thoughts