EMORY HEALTHCARE

SECTION OF NEUROSURGERY
PATIENT INFORMATION SHEET

EC#: _____
(for office use only)

Patient's Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Physician you are seeing today: _____

Marital Status:
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Single

Work Status:
- ☐ Employed as: _____
- ☐ Workers' Compensation
- ☐ Retired
- ☐ Disabled
- ☐ Unemployed

General Health Status:
- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Are You:
- ☐ Right-Handed
- ☐ Left-Handed

Please list all the physicians you are currently seeing and/or whom you want to be informed about your progress:

Physician who referred you: Name: _____

Address: _____

_____

Telephone: ( ) _____ Fax: ( ) _____

Your Family Physician: Name: _____

Address: _____

_____

Telephone: ( ) _____ Fax: ( ) _____

Other Physician: Name: _____

Address: _____

_____

Telephone: ( ) _____ Fax: ( ) _____

1. Please describe the type of medical problem or symptoms that you are being seen for today: _____

_____

_____

2. Were you injured at work? Were you injured in a motor vehicle accident? If yes, explain: _____

_____

_____

Date of Injury: _____ Date you last worked: _____

Attorney's Name and Address: _____

_____

3. Do you now or have you ever had the following:

Heart problems	☐ Yes	☐ No		Diabetes or problems with blood sugar	☐ Yes	☐ No	
Lung problems	☐ Yes	☐ No		GI problems (i.e., ulcers, hiatal hernia, gastritis)	☐ Yes	☐ No	
Kidney problems	☐ Yes	☐ No		Liver disease (such as hepatitis)	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No		Problems with blood (i.e., clotting problems)	☐ Yes	☐ No	
				Any type of cancer	☐ Yes	☐ No	

Other: _____

4. Please list all surgeries you have had, including the year they were performed: _____

_____

_____

5. Have you ever had radiation therapy? ☐ Yes ☐ No
   Have you ever had chemotherapy? ☐ Yes ☐ No

Please list the date(s) and the facility where you were treated: _____

_____

6. Please list any medications you are currently taking. List the name of the medication, the frequency, and the dosage: ____

_____

_____

7. Are you allergic to any medications? Please list the name of the medication and the reaction caused by taking the medication.

_____

_____

8. Have you ever had a reaction to any dye given for a special test? If so, what was the test, and what kind of reaction did you have? _____

_____

9. Do you use:

A. Tobacco	☐ Yes ☐ No	How much per day?	_____
B. Alcohol	☐ Yes ☐ No	How much per day?	_____
C. Drugs	☐ Yes ☐ No	How much per day?	_____

10. Are you on a special diet? If so, please specify the type of diet. _____

_____

11. How many hours of sleep per night do you get on average? _____ hours.

12. Is there other information about yourself that you would like for us to know? _____

_____

13. Has anyone in your immediate family had:

A. High Blood Pressure	☐ Yes ☐ No	If so, who?	_____
B. Heart Disease	☐ Yes ☐ No	If so, who?	_____
C. Cancer	☐ Yes ☐ No	If so, who?	_____
D. Diabetes	☐ Yes ☐ No	If so, who?	_____
E. Asthma	☐ Yes ☐ No	If so, who?	_____
F. Stroke	☐ Yes ☐ No	If so, who?	_____
G. Seizures	☐ Yes ☐ No	If so, who?	_____
H. Migraine	☐ Yes ☐ No	If so, who?	_____

I. Other (please list): _____

14. Please provide the following information:

	If Living:	If Deceased:
Mother	Age: _____	At what age: _____
	Health Status: _____	Cause of Death: _____
Father	Age: _____	At what age: _____
	Health Status: _____	Cause of Death: _____

15. Do you have any living siblings? If so, how many? _____ Brothers _____ Sisters
16. If you have deceased siblings?

Sex	Age at Death	Cause of Death
_____	_____	_____
_____	_____	_____

17. Do you have any living children? If so, how many? _____
18. If you have deceased children?

Sex	Age at Death	Cause of Death
_____	_____	_____
_____	_____	_____

REVIEW OF SYSTEMS: Are you currently experiencing any of the following symptoms? Please check yes or no. If you are not sure, please leave blank.

NO	YES	GENERAL	OFFICE USE ONLY COMMENTS
☐	☐	Weakness	
☐	☐	Tiredness	
☐	☐	Lack of appetite	
☐	☐	Excess appetite	
☐	☐	Weight loss	
☐	☐	Weight gain	
☐	☐	Chills	
☐	☐	Fever	
☐	☐	Night sweats	
☐	☐	Difficulty sleeping	

NO	YES	EYES, EARS, NOSE, THROAT	COMMENTS
☐	☐	Decreased ability to see	
☐	☐	Blurred vision	
☐	☐	Spots before your eyes	
☐	☐	Pain in the eyes	
☐	☐	Difficulty in hearing	
☐	☐	Ringing in your ears	
☐	☐	Discharge from the ears	
☐	☐	Nasal discharge (frequent)	

NO	YES	RESPIRATORY	COMMENTS
☐	☐	Cough	
☐	☐	Wheezing	
☐	☐	Asthma	
☐	☐	Shortness of breath	
☐	☐	Shortness of breath with exertion	
☐	☐	Pain in chest when you cough, sneeze or move	

FOR OFFICE USE ONLY

NO	YES	CARDIOVASCULAR	COMMENTS
☐	☐	Chest pain, tightness or squeezing	
☐	☐	Shortness of breath lying down	
☐	☐	Need to sit up to breathe	
☐	☐	Heart racing	
☐	☐	Irregular heart beat (palpitations)	
☐	☐	Heart murmur	
☐	☐	Swelling of the legs	
☐	☐	Varicose veins	
☐	☐	Leg pain at rest	
☐	☐	Leg pain with exertion	
☐	☐	Blue/purple discoloration of hands/feet	

NO	YES	GASTROINTESTINAL	COMMENTS
☐	☐	Nausea	
☐	☐	Vomiting	
☐	☐	Diarrhea	
☐	☐	Constipation	
☐	☐	Heartburn	
☐	☐	Abdominal pain	
☐	☐	Bright red blood in stools	
☐	☐	Black stools	
☐	☐	Change in bowel habits	
☐	☐	Need for antacids	

NO	YES	URINARY	COMMENTS
☐	☐	Urinary tract infections	
☐	☐	Pain or burning on urination	
☐	☐	Frequent urination-day	
☐	☐	Frequent urination-night	
☐	☐	Unusually large volumes of urine	
☐	☐	Extreme urge to urinate	
☐	☐	Difficulty starting urinary stream	
☐	☐	Difficulty stopping urinary stream	
☐	☐	Kidney stones	

NO	YES	GENITO-REPRODUCTIVE (MALE)	COMMENTS
☐	☐	History of sexually transmitted disease	
☐	☐	Discharge from penis	
☐	☐	Testicular pain	
☐	☐	Lumps in testicles or scrotum	
☐	☐	Decrease in testicular size	
☐	☐	Decreased sexual desire	
☐	☐	Decreased ability to achieve erection	

FOR OFFICE USE ONLY

NO	YES	GENITO-REPRODUCTIVE (FEMALE)	COMMENTS
		Age at onset of menstrual periods	
		Age which periods stopped (menopause)	
		How far apart are your periods?	
		How many days do they last?	
		Is flow heavy, scanty or normal? (Circle one)	
☐	☐	Do you ever bleed between periods?	
		What is the date of your last normal period?	
		What is the date of the last period before that?	
☐	☐	Have you had any sexually transmitted diseases?	
☐	☐	Do you have decreased sexual drive?	
☐	☐	Have you had vaginal bleeding since menopause?	
☐	☐	Are you bothered by hot flashes?	
☐	☐	Are you taking any female hormones?	

NO	YES	MUSCULOSKELETAL	COMMENTS
☐	☐	Muscle pain	
☐	☐	Neck pain	
☐	☐	Shoulder or arm pain	
☐	☐	Back pain	
☐	☐	Pain down your legs	
		☐ Right side? ☐ Left side?	
☐	☐	Painful joints	
☐	☐	Swelling of any joints	
☐	☐	Redness of any joints	
☐	☐	Stiffness of any joints	
☐	☐	Deformities of the joints or extremities	

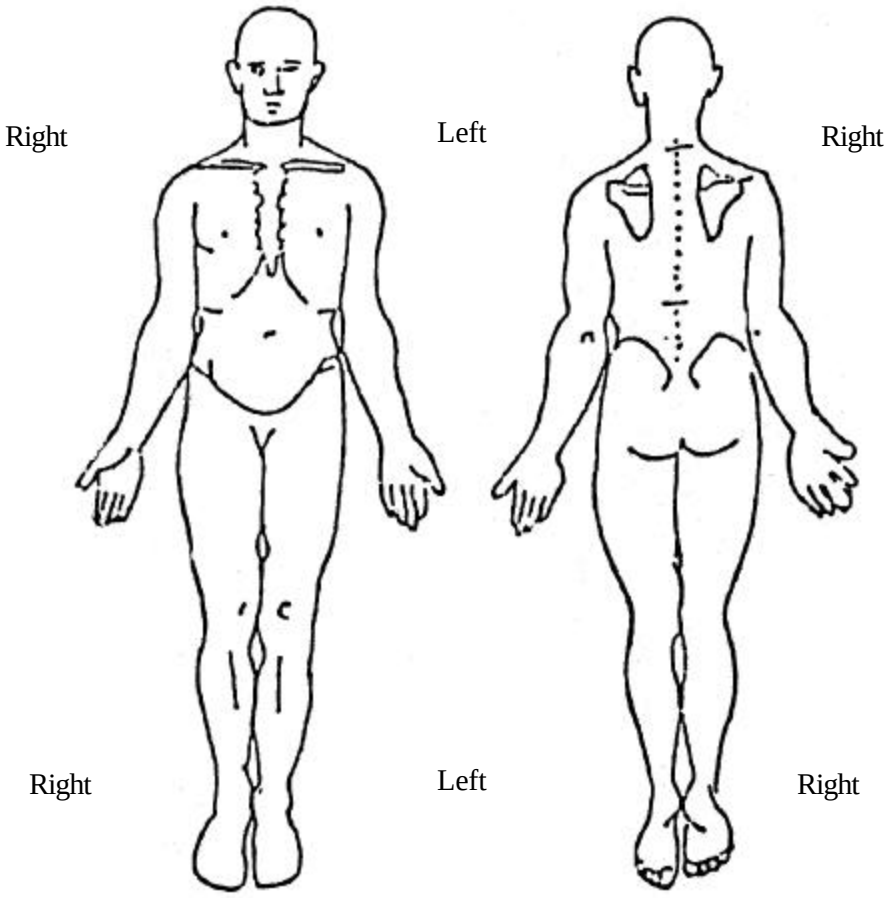
NO	YES	ENDOCRINE	COMMENTS
☐	☐	Goiter	
☐	☐	Heat intolerance	
☐	☐	Cold intolerance	
☐	☐	Tremulousness of the hands	
☐	☐	Change in pitch of the voice	
☐	☐	Increased body hair (face, under arms, pubic)	
☐	☐	Decreased body hair (face, under arms, pubic)	
☐	☐	Decrease in breast size	
☐	☐	Loss of periods (disregard if from normal menopause)	
☐	☐	Increased thirst	
☐	☐	Increased urination	
☐	☐	Marked increase in appetite	
☐	☐	Increase in breast size	

FOR OFFICE USE ONLY

NO	YES	NEUROLOGIC/PSYCHIATRIC	COMMENTS
☐	☐	Seizures	
☐	☐	Headaches	
☐	☐	Blackouts	
☐	☐	Dizziness	
☐	☐	Double vision	
☐	☐	Paralysis or weakness of limb(s)	
☐	☐	Loss of sensation	
☐	☐	Loss of balance	
☐	☐	Loss of coordination	
☐	☐	Difficulty in speaking	
☐	☐	Nervousness	
☐	☐	Depression	
☐	☐	Difficulty in going to sleep	
☐	☐	Early morning awakening	
☐	☐	Difficulty with memory for past events	
☐	☐	Difficulty with memory for recent events	
☐	☐	Difficulty with thinking or problem solving	

NO	YES	SKIN	COMMENTS
☐	☐	Dryness of skin	
☐	☐	Itching	
☐	☐	Rash	
☐	☐	Change in skin color	
☐	☐	Change in texture of the hair	
☐	☐	Change in skin temperature	
☐	☐	Falling out of the hair	
☐	☐	Nail changes	
☐	☐	Skin ulcers	

If you have pain, numbness, or tingling, please complete the following:



Please indicate with an "X" or "O" on the accompanying diagrams the location of your symptoms.

X = Pain

O = Numbness

Severity (if applicable)

- ☐ Constant
- ☐ Occasional
- ☐ Wakes you up
- ☐ Difficulty walking

Description

- ☐ Aches
- ☐ Throbs
- ☐ Burns
- ☐ Tingles
- ☐ Stabbing
- ☐ Numbness

Indicate current level of pain on the following scale:

☐ No Pain 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 Intolerable ☐ 10

What makes your condition worse? _____

What helps your condition? _____

Other body parts affected: _____

Symptoms affected by: _____

What kind of effect do the following activities have on your symptoms?

	Sitting	Standing	Exercise	Rest
Increase				
Decrease				

EMORY HEALTHCARE