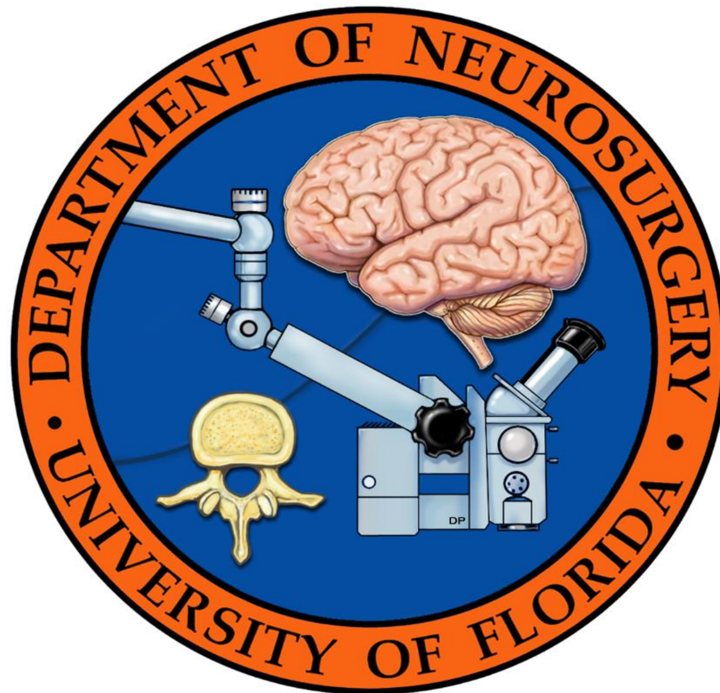
In preparation for your scheduled appointment, please be sure:

- **You have completed and signed this form**
- **You have all pertinent medical records**
- **If you have a cardiac history, bring results of your last EKG and/or other tests**
- **You have your X-ray/CT/MRI scan on CD/films, not just reports**
- **You have your insurance card.**

Do not hesitate to call our office at 352-273-9000 if you have questions or need assistance in completing this form.



NEUROSURGICAL SPECIALTIES @ UF HEALTH SHANDS
PATIENT HEALTH HISTORY QUESTIONNAIRE

The information below is extremely important.
Please fill out this form on front and back of each page.
Be sure to bring this with you to your scheduled clinic appointment.

Date: _______________

Patient Name: ____

Medical Record # _______________________ DOB: ____/____/_____ Age:_______

Contact Phone: _____-_____-______ Family Contact Name: ____________________________

Contact Phone: ______-_____-_______

Currently seeing a specialist? If yes, who? ____

Contact Number: __________________________________

Are you allergic to any medicines, X-ray dye or iodine? ☐ Yes ☐ No

If so, what and reaction?

____

____

____

____

List all medications you take routinely, along with the dose.
Include vitamins, supplements and Over-the-Counter medications

Medication	Strength	Dose	Frequency

Are you taking any "blood thinning" medications? ☐ Yes - Please indicate below ☐ No

☐ Aspirin or aspirin containing medication ☐ Anti-inflammatory medication ☐ Plavix

☐ Fish Oil ☐ Coumadin ☐ Other________________________

HISTORY

Medical History

Allergies	**YES**	**NO**	COPD	**YES**	**NO**	Kidney Disease	**YES**	**NO**
Anemia	**YES**	**NO**	Depression	**YES**	**NO**	Meningitis	**YES**	**NO**
Anesthetic complications	**YES**	**NO**	Diabetes mellitus	**YES**	**NO**	Nerve/muscle disease	**YES**	**NO**
Anxiety	**YES**	**NO**	Emphysema	**YES**	**NO**	Osteoporosis	**YES**	**NO**
Arthritis	**YES**	**NO**	GER	**YES**	**NO**	Seizures	**YES**	**NO**
Asthma	**YES**	**NO**	Glaucoma	**YES**	**NO**	Sickle Cell	**YES**	**NO**
Blood Transfusion	**YES**	**NO**	Heart Attack	**YES**	**NO**	Stroke	**YES**	**NO**
Cancer	**YES**	**NO**	Heart Murmur	**YES**	**NO**	Substance abuse	**YES**	**NO**
Cataracts	**YES**	**NO**	HIV/AIDS	**YES**	**NO**	Thyroid disease	**YES**	**NO**
CHF	**YES**	**NO**	Hyperlipidemia	**YES**	**NO**	Tuberculosis	**YES**	**NO**
Clotting Disorder	**YES**	**NO**	Hypertension	**YES**	**NO**	Ulcers	**YES**	**NO**

Atrial fibrillation, pacemaker (model/company)____________________________________

Have you had lung function testing? ____

Have you had a special heart test (Echo, Stress test, Cath)?____________________________

Can you climb a flight of stairs without stopping? __________________________________

Have you been diagnosed with sleep apnea (CPAP, Sleep study)? ________________________

If yes, date and details:

____

____

____

____

____

Surgical History

Appendectomy	**YES**	**NO**	Colon surgery	**YES**	**NO**	Joint replacement	**YES**	**NO**
Brain surgery	**YES**	**NO**	Cosmetic surgery	**YES**	**NO**	Small intestine surgery	**YES**	**NO**
Breast Surgery	**YES**	**NO**	Eye surgery	**YES**	**NO**	Spine surgery	**YES**	**NO**
C-Section	**YES**	**NO**	Fracture surgery	**YES**	**NO**	Tubal ligation	**YES**	**NO**
CABG	**YES**	**NO**	Hernia repair	**YES**	**NO**	Valve replacement	**YES**	**NO**
Cholecystectomy	**YES**	**NO**	Hysterectomy	**YES**	**NO**	Vasectomy	**YES**	**NO**

If yes, date and details:

____

____

____

____

Relationship	Name	Living/Deceased	No Known Problems	Arthritis	Asthma	Birth Defects	Cancer	Dementia	Depression	Diabetes	Early Death	GERD	Gout	Hearing Loss	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Learning Disability	Leukemia	Lymphoma	Mental Illness	Mental Retardation	Migraine	Miscarriage	Neuropathy	Old Age	Other	Stroke	Substance Abuse	Vision Loss
Mother																															
Father																															
Sister																															
Brother																															
Maternal Aunt																															
Maternal Uncle																															
Paternal Aunt																															
Paternal Uncle																															
M-Grandmother																															
M-Grandfather																															
P-Grandmother																															
P-Grandfather																															

SOCIAL HISTORY

Tobacco Use: **YES** **NO** **Former User** Start Date:

Packs/Day: Quit Date:

Years:

Smokeless Tobacco **YES** **NO** Quit Date:

Comments: ____________________

Alcohol Use: **YES** **NO**

Drinks/Week
______ Glasses of Wine
______ Cans of beer
______ Shots of liquor

Comments: ____________________

Drug Use: **YES** **NO**

Times per week? ______ Types: Marijuana Methamphetamines Cocaine IV

Comments: ____________________

Sexually Active **YES** **NO** **NOT CURRENTLY**

SOCIAL CONCERNS

Family/Domestic Violence? **YES NO** Blood Transfusion 1978-1985? **YES NO**

Exercise? **YES NO**

Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

What is your occupation? ______________________________

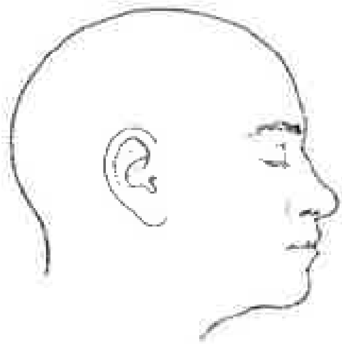
____

On the scale of 1 to 10 below, with 10 being the worst pain you can imagine and 1 being essentially no pain, please rate the typical or average amount of pain you have during the day. Circle a number

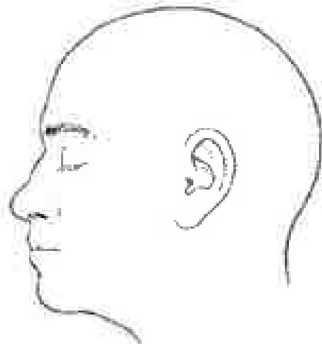
1	2	3	4	5	6	7	8	9	10

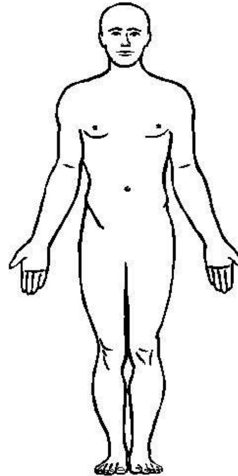
On the diagram below, indicate where your pain is usually located. Please shade the painful areas.

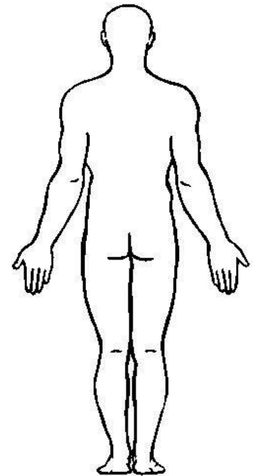
RIGHT



LEFT







REVIEW OF SYSTEMS

Do you currently, or have you had, a problem with:

Constitutional:

Fever	**YES**	**NO**
Weight Loss	**YES**	**NO**
Excessive Fatigue	**YES**	**NO**

Eyes:

Wear glasses	**YES**	**NO**
Infections	**YES**	**NO**
Injuries	**YES**	**NO**
Glaucoma	**YES**	**NO**
Cataracts	**YES**	**NO**

Ear, Nose, Throat & Mouth

Wear hearing aid(s)	**YES**	**NO**
Hearing loss	**YES**	**NO**
Ear pain	**YES**	**NO**
Ear infections	**YES**	**NO**
Ringing in ears	**YES**	**NO**
If yes, circle one: LEFT RIGHT BOTH		
Nose bleeds	**YES**	**NO**
Nasal congestion	**YES**	**NO**
Nasal drainage	**YES**	**NO**
Inability to smell	**YES**	**NO**
Sinus problems	**YES**	**NO**
Balance disturbance (vertigo, spinning, etc)	**YES**	**NO**

Cardiovascular

Chest pain or angina	**YES**	**NO**
High blood pressure	**YES**	**NO**
Irregular pulse	**YES**	**NO**
Heart murmur	**YES**	**NO**
High cholesterol	**YES**	**NO**
Swelling in hands or feet	**YES**	**NO**
Leg pain while walking	**YES**	**NO**

Respiratory

Asthma	**YES**	**NO**
Emphysema	**YES**	**NO**
Shortness of Breath	**YES**	**NO**
Pneumonia	**YES**	**NO**
Lung cancer	**YES**	**NO**
Bloody Sputum	**YES**	**NO**

Gastrointestinal

Nausea	**YES**	**NO**
Vomiting	**YES**	**NO**
Blood in your vomit	**YES**	**NO**
Liver disease	**YES**	**NO**
Jaundice	**YES**	**NO**
Abdominal pain	**YES**	**NO**
Change in bowel habits	**YES**	**NO**
Ulcers or Gastritis	**YES**	**NO**
Colon cancer	**YES**	**NO**

Genitourinary

Urinary tract infection	**YES**	**NO**
Pain urination	**YES**	**NO**
Blood in your urine	**YES**	**NO**
Difficult starting/stopping stream	**YES**	**NO**
Incontinence	**YES**	**NO**
Kidney stones	**YES**	**NO**
Prostate Cancer (male)	**YES**	**NO**
Uterine or cervical cancer (female)	**YES**	**NO**

Musculoskeletal

Broken bones	**YES**	**NO**
Arm or leg weakness	**YES**	**NO**
Arm or leg pain	**YES**	**NO**
Joint pain or swelling	**YES**	**NO**
Arthritis	**YES**	**NO**

Integumentary

Skin disease	**YES**	**NO**
Skin cancer	**YES**	**NO**
Breast pain, tenderness (female)	**YES**	**NO**
Nipple discharge (female)	**YES**	**NO**

Neurological

Fainting spells or "black outs"	**YES**	**NO**
Seizures	**YES**	**NO**
Problems with memory	**YES**	**NO**
Disorientation	**YES**	**NO**
Difficulty with speech	**YES**	**NO**
Inability to concentrate	**YES**	**NO**
Double or blurred vision	**YES**	**NO**
Weakness in arms and/or legs	**YES**	**NO**
Loss of sensation	**YES**	**NO**
Difficulty with balance	**YES**	**NO**

Psychiatric

Anxiety Depression	**YES**	**NO**
Other psychiatric disorder and/or treatment: ______________________________________ ______________________________________	**YES**	**NO**

Hematologic/Lymphatic

Anemia	**YES**	**NO**
Hemophilia	**YES**	**NO**
Bleeding tendencies	**YES**	**NO**
Blood transfusion	**YES**	**NO**
Persistent swollen glands or lymph nodes	**YES**	**NO**

Allergic/Immunologic

Food allergies	**YES**	**NO**
Inhalant (nasal) allergies	**YES**	**NO**
Autoimmune disease (lupus, rheumatoid arthritis, etc.)	**YES**	**NO**

Endocrine				
Diabetes	**YES**	**NO**		
Thyroid disease	**YES**	**NO**		
Excessive thirst/urination	**YES**	**NO**		

The information on this form is accurate to the best of my knowledge:

Patient Signature **Date Completed**

Department of Neurosurgery
University of Florida