Providence Neurosurgery
PATIENT INFORMATION SHEET

Staff only:
Weight: _____
Height: _____
BP: _____
Pain_____
Age _____

Date: _____

_____ _____
Patient Name **Date of Birth**

_____ _____ _____ _____
Street Address **City** **State** **Zip Code**

_____ _____ _____
Home Phone Work Phone Cell Phone

❍ Right handed
❍ Left handed
Please mark one

_____ _____
Referring Physician City

Name of primary care provider/physician:_____

Are you currently being treated by a chiropractor? ❍ No ❍ Yes
If yes, name: _____

Are you currently being treated by a physical therapist? ❍ No ❍ Yes
If yes, name: _____

May we send information about your treatment here to the above practitioners/physicians? ❍ No ❍ Yes

Explain briefly why you are being seen: _____
_____

Date of injury/onset: _____ Circumstances of injury/onset:
_____

Have you ever had similar problem? ❍ No ❍ Yes If yes, please describe: _____
_____

Drug Allergies and Reactions (Please list allergy and reaction):

Allergy	Reaction

Are you allergic to any of the following:

Shellfish	❍ No ❍ Yes	X-ray contrast	❍ No ❍ Yes
Metal	❍ No ❍ Yes	Latex/rubber	❍ No ❍ Yes
Costume Jewelry	❍ No ❍ Yes	Soap	❍ No ❍ Yes
Iodine	❍ No ❍ Yes	Tape	❍ No ❍ Yes

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Current Medications (please include all prescription, over-the-counter drugs, birth control pills and vitamins)

Name of Medication	Reason	Dose	Frequency

Past Medical History (please check any current or past problems)

- ☐ Depression
- ☐ Lung Disease
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Liver abnormality
- ☐ Asthma
- ☐ Arthritis
- ☐ Blood clot or deep venous thrombosis (DVT)
- ☐ Thyroid Disorder
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Tick Bites
- ☐ Cancer
- ☐ Sleep apnea
- ☐ Kidney/bladder problems
- ☐ Blood abnormality
- ☐ Heart Disease/attack
- ☐ High blood pressure
- ☐ HIV or exposure
- ☐ Diabetes yr onset____
- ☐ Back pain child/adult
- ☐ Other _____
- ☐ Stroke
- ☐ Seizures
- ☐ Pacemaker
- ☐ Glaucoma
- ☐ Rash
- ☐ Psoriasis

Do you have a current gum or dental infection? ❍ No ❍ Yes

Surgery History:

Surgery Name	Surgery Date	Location where performed

1. ❍ No ❍ Yes Have you had surgical complications?
   If yes, describe: _____
2. ❍ No ❍ Yes Have you had an adverse reaction to general anesthesia?
   If yes, describe: _____
3. ❍ No ❍ Yes Have any immediate family members had an adverse reaction to general anesthesia?
   If yes, describe: _____
4. ❍ No ❍ Yes Have you had a blood transfusion? Approximate year: _____
5. ❍ No ❍ Yes Is there any reason you could not receive blood if needed during surgery?
6. ❍ No ❍ Yes Are you pregnant?

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Social History

Are you currently: ☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Domestic Partner

Are you currently employed? ❍ No ❍ Yes Occupation: _____

❍ No ❍ Yes Do you currently use tobacco? If yes, do you:
❍ No ❍ Yes Smoke cigarettes How many per day? _____ Years of use _____
❍ No ❍ Yes Cigar/pipe How many per day? _____ Years of use _____
❍ No ❍ Yes Chew tobacco How many cans per week? ____ Years of use _____

❍ No ❍ Yes Are you a former smoker/tobacco user? If yes, what age did you quit:_____
❍ No ❍ Yes Have you ever used recreational/non-medical drugs? If yes, type:_____
❍ No ❍ Yes Do you use alcohol ? If yes, amount per day or week:_____

Family History (Please describe the health history of your family members)

Relationship	Age (at death if deceased)	Health Status (living or deceased)	Medical problem or cause of death
Spouse			
Mother			
Father			
Child			
Child			
Child			

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Please mark any of the following you are experiencing:

Constitutional:	Head/Ear/Eyes/Nose/ Throat:	Respiratory:
☐ Loss of appetite	☐ Loss of vision	☐ Coughed blood
☐ Fever or chills	☐ Headache	☐ Asthma/ wheezing
☐ Chronic Fatigue	☐ Hearing difficulty	☐ Cough
☐ Recent infections	☐ Eye or mouth dryness	☐ Shortness of breath
☐ Problems sleeping	**Cardiovascular:**	**Other:**
☐ Weight loss	☐ Chest pain	☐ Menstrual difficulty
☐ Weakness	☐ Irregular heartbeat	☐ Stiff joints
☐ Bleeding disorder	☐ Circulation problems	☐ Swollen joints

GI/GU:	Neurological:	
☐ Abdominal pain	☐ Dizziness	☐ Poor coordination
☐ Nausea	☐ Impaired thinking	☐ Seizure
☐ Constipation	☐ Ringing in ears	☐ Numbness/tingling
☐ Bloody urine	☐ Lack of bladder control	☐ Speech difficulty
☐ Vomiting	☐ Difficulty with taste/smell	☐ Blackouts or fainting
☐ Heartburn	☐ Memory problems	☐ Meningitis, encephalitis
☐ Stomach ulcer	☐ Difficulty walking	☐ Swallowing difficulty
☐ Diarrhea	☐ Back, neck, head injury	☐ Sexual function problems
☐ Bowel incontinence	☐ Depression	☐ Decreased attention
☐ Black/bloody stools	☐ Tremor or shaking	☐ Personality changes
	☐ Double vision	

Other symptoms you have experienced (please describe):

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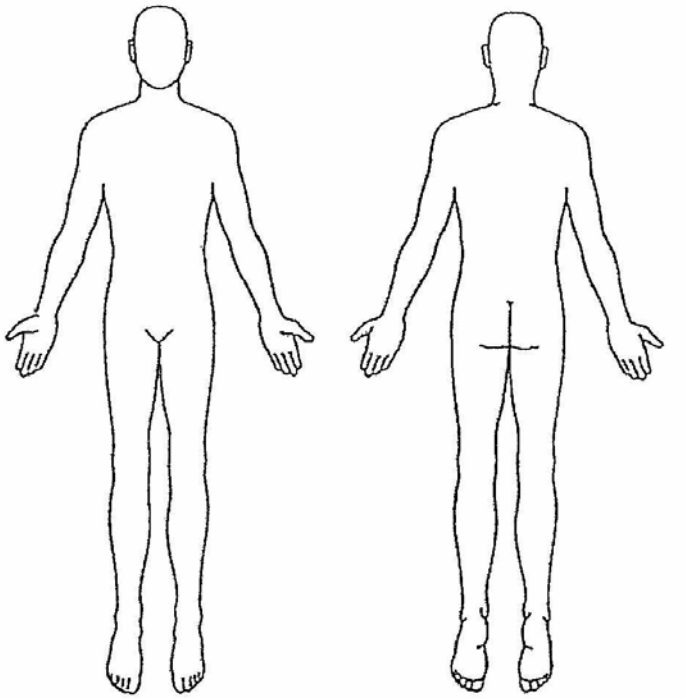
Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Ache: AAAA Numbness: NNNN Burning: BBBB Stabbing: SSSS Tingling: TTTT
AAAA NNNN BBBB SSSS TTTT



FRONT **BACK**

Please rate your pain on a scale of 1 – 10.
1 = none or least amount of pain
10 = most severe pain imaginable

Today:	___	___	___	___	___	___	___	___	___	___
	1	2	3	4	5	6	7	8	9	10
Least:	___	___	___	___	___	___	___	___	___	___
	1	2	3	4	5	6	7	8	9	10
Worst:	___	___	___	___	___	___	___	___	___	___
	1	2	3	4	5	6	7	8	9	10

I attest all information I have provided is true and correct to the best of my knowledge.

_____ _____
Patient Signature Date

_____ _____
Physician Signature Date