

# Southwest Neurosurgical Associates

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Please complete all lines on this form by filling in the blanks or checking the boxes. Your cooperation will help us to more thoroughly evaluate your medical problem and help determine if you are a surgical candidate.

Name \_\_\_\_\_ age \_\_\_\_\_ DOB: \_\_\_\_\_ today's date \_\_\_\_\_  
Referring physician \_\_\_\_\_ primary care physician \_\_\_\_\_  
Right handed \_\_\_\_\_ left handed \_\_\_\_\_ approximate weight \_\_\_\_\_  
Employer \_\_\_\_\_ phone number \_\_\_\_\_

## **CURRENT MEDICAL HISTORY**

**Briefly describe your current medical problem that brings you to our office today:**

Where is the pain located? \_\_\_\_\_

Is your pain: \_\_\_\_\_ constant \_\_\_\_\_ comes and goes \_\_\_\_\_ worse in the morning \_\_\_\_\_ worse late in day

Is your pain \_\_\_\_\_ burning \_\_\_\_\_ stabbing \_\_\_\_\_ aching \_\_\_\_\_ throbbing \_\_\_\_\_ sharp \_\_\_\_\_ dull

Is your pain \_\_\_\_\_ mild \_\_\_\_\_ moderate \_\_\_\_\_ severe

Describe anything that makes the pain worse \_\_\_\_\_

Describe anything that makes the pain better \_\_\_\_\_

Describe distribution of pain as a percentage of 100%(i.e.back 50% and leg 50%, or as neck 50% and arm 50%) back \_\_\_\_\_ leg \_\_\_\_\_ neck \_\_\_\_\_ arm \_\_\_\_\_

Do you have numbness? If so, where \_\_\_\_\_

Do you have weakness? If so, where \_\_\_\_\_

Do you have bladder or bowel problems? \_\_\_\_\_

Have you have had any \_\_\_\_\_ physical therapy \_\_\_\_\_ chiropractic therapy \_\_\_\_\_ acupuncture  
\_\_\_\_\_ epidural injections.

## **REVIEW OF SYSTEMS**

### **Constitutional symptoms**

\_\_\_\_\_ weight loss

\_\_\_\_\_ fever

### **eyes, ear, nose, mouth, throat**

\_\_\_\_\_ vision loss

\_\_\_\_\_ double vision

\_\_\_\_\_ hearing loss

\_\_\_\_\_ hoarseness

\_\_\_\_\_ trouble swallowing

### **cardiovascular**

\_\_\_\_\_ hypertension

\_\_\_\_\_ chest pain (angina)

\_\_\_\_\_ heart attack

\_\_\_\_\_ shortness of breath

\_\_\_\_\_ irregular heart

\_\_\_\_\_ blood clots in legs or lungs

### **respiratory**

\_\_\_\_\_ emphysema

\_\_\_\_\_ asthma

\_\_\_\_\_ chronic obstructive disease

gastrointestinal

- vomiting
- hepatitis
- ulcers

genitourinary

- unable to control urine

musculoskeletal

- spine fracture
- muscle wasting
- osteoporosis
- arthritis

integument

- hair loss

neurological

- seizures
- paralysis
- tremors
- stroke

psychiatric

- sleep disturbance
- difficulty with work
- fatigue
- anxiety
- depression

endocrine

- frequent urination
- excessive thirst

hematological

- anemia
- bleeding disorder

PAST MEDICAL HISTORY

List your current or previous severe illnesses such as diabetes, high blood pressure, heart attack, cancer, etc. \_\_\_\_\_

List your severe injuries such as broken bones \_\_\_\_\_

List your surgeries \_\_\_\_\_

List your allergies \_\_\_\_\_

MEDICATIONS:

<u>MEDICATION</u>	<u>DOSE</u>	<u>REASON</u>

FAMILY HISTORY

Do you have a family history of the following?

- |  |   |
|--|---|
| <input type="checkbox"/> stroke        | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> diabetes      | <input type="checkbox"/> bleeding       |
| <input type="checkbox"/> hypertension  | <input type="checkbox"/> cancer         |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> hepatitis      |

SOCIAL HISTORY:

Smoke cigarettes \_\_\_\_\_ how many packs per day \_\_\_\_\_ how many years smoked \_\_\_\_\_

If you quit, what year \_\_\_\_\_ how much did you smoke when you quit \_\_\_\_\_

Do you consume alcoholic beverages?  yes  no \_\_\_\_\_ what kind \_\_\_\_\_ how much \_\_\_\_\_

Do you have any risk factors for AIDS virus \_\_\_\_\_

Current profession \_\_\_\_\_

Past profession if retired \_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_