SOUTHWEST NEUROSURGICAL ASSOCIATES

8080 ACADEMY ROAD NE, SUITE B, ALBUQUERQUE, NM 87111
PHONE: 505-244-0080 FAX: 505-244-9048
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Andrew K. Metzger, M.D.
Jeffrey W. Haughton, PA-C

Date: _____/_____/___Name:_______________________________________Age:_________________DOB: _____/_____/___

Referring physician:__________________________________Primary care physician:_____________________________________

Dominant hand ☐ Right ☐ Left weight________ height________

Reason for visit ☐ Neck ☐ Back ☐ Brain ☐ Other ___________________________

Current history for neck or back problems:

Briefly describe your current symptoms that bring you to our office today:____

____

Do you have pain ☐ No ☐ Yes *(if yes is the pain)* ☐ mild ☐ moderate ☐ severe

Where is the pain located?____

When did it start? ____

Did you have an accident or injury? ☐ No ☐ Yes If yes please describe: ______________________________________

Was it work-related? ☐ No ☐ Yes If yes please describe: ____

Please check all that apply to describe your pain:

☐ Constant ☐ Comes and goes ☐ Worse in the morning ☐ Worse late in day

☐ Burning ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Sharp ☐ Dull

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 _________ *(total = 100%)*

Do you have numbness: ☐ No ☐ Yes with location:____

Do you have weakness: ☐ No ☐ Yes with location:____

Do you have bladder or bowel problems: ☐ No ☐ If yes how long?_____________________________________

Previous treatments: ☐ physical therapy ☐ chiropractic therapy ☐ acupuncture ☐ epidural injections If so, where and when did you have injections? ____

List all allergies:____

MEDICATIONS: (if you have your own medication list please give us a copy instead of filling out the spaces below)

Name	**Dose and frequency**	**Reason**

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Past medical history:

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

____

____

____

List any previous surgery:____

____

____

____

REVIEW OF BODY SYSTEMS *(please check any that apply to you)*

Constitutional symptoms	☐ Weight loss ☐ Weight gain ☐ Fever
Eyes, ear, nose, mouth, throat	☐ Vision loss ☐ double vision ☐ hearing loss ☐ hoarseness ☐ trouble swallowing
Musculoskeletal	☐ spine fracture ☐ muscle wasting ☐ osteoporosis ☐ arthritis
Integument	☐ hair loss
Cardiovascular	☐ hypertension ☐ chest pain (angina) ☐ heart attack ☐ shortness of breath ☐ irregular heart ☐ blood clots in legs or lungs
Respiratory	☐ emphysema ☐ asthma ☐ chronic obstructive disease ☐ Oxygen use
Gastrointestinal	☐vomiting ☐hepatitis ☐ ulcers
Genitourinary	☐ Unable to control urine ☐ kidney disease
Neurological	☐ seizures ☐ paralysis ☐ tremors ☐ stroke
Psychiatric	☐ sleep disturbance ☐ difficulty with work ☐ fatigue ☐ anxiety ☐ depression
Endocrine	☐ frequent urination ☐ excessive thirst
Hematological	☐ anemia ☐ bleeding disorder
Imaging	☐ claustrophobia ☐ reaction to dye or contrast ☐ metal or implants
If yes to the imaging section please describe:	

FAMILY HISTORY: Do you have a family history of any of the following?

☐ stroke ☐ kidney disease ☐ diabetes ☐ bleeding ☐ hypertension ☐ cancer ☐heart disease ☐ hepatitis ☐ psychiatric disorders

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? ☐ no ☐ yes what kind?_________________ frequency ________________

Do you use recreational drugs? ☐ no ☐ yes

Current profession: ______________________________ Past profession if retired:______________________

Does the problem you are being evaluated for involve any legal matter? ☐ No ☐ Yes *(if yes please explain)*__________

____

Have you seen another neurosurgeon or an orthopedic surgeon for this problem ☐ No ☐ Yes *(if yes please explain)*_____

____

________________________________ ________________________________ ___/___/___

Print Name Signature Date