





# SOUTHWEST NEUROSURGICAL ASSOCIATES

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

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

## 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 neurologist for this problem  No  Yes *(if yes please explain)* \_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date