SOUTHWEST NEUROSURGICAL ASSOCIATES
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PATIENT BRAIN HISTORY FORM

Name: _____ Age: _____ DOB: _____/_____/____ Today's Date: _____/_____/_____

Referring physician:_____Primary care physician:_____

Dominant hand: ☐ right ☐ left height: _____ weight:_____

CURRENT BRAIN HISTORY:

Please check all that apply:

☐ weakness ☐ numbness ☐ facial pain ☐ nausea ☐ speech change ☐ difficulty walking

☐ tremors: ☐ right ☐ left ☐ both

☐ hearing loss: ☐ right ☐ left ☐ both

☐ seizures, frequency: _____ location: _____

☐ visual changes, describe: _____

If you have pain when did it first start? _____

Where is your pain located? _____

Is your pain: ☐ constant, ☐ comes & goes, ☐ worse AM, ☐ worse PM

Is your pain: ☐ shooting, ☐ stabbing, ☐ sharp, ☐ jabbing, ☐ shock-like

Is your pain: ☐ dull, ☐ pounding, ☐ aching, ☐ throbbing, ☐ pressure-like

Is your pain: ☐ mild, ☐ moderate, ☐ severe, ☐ unbearable

Do you have numbness? Where? _____

Do you have weakness? Where? _____

Do you have bladder or bowel problems? _____

Describe what makes your pain worse. _____

Describe what makes your pain better. _____

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Please check the box with any conditions that apply to you:

Constitutional:
- ☐ sudden weight loss
- ☐ sudden weight gain
- ☐ fevers

Integument
- ☐ sudden hair loss

Eyes, ears, nose, mouth, throat
- ☐ vision loss
- ☐ double vision
- ☐ hearing loss
- ☐ hoarseness
- ☐ trouble swallowing

Cardiovascular
- ☐ hypertension
- ☐ chest pain (angina)
- ☐ heart attack
- ☐ shortness of breath
- ☐ irregular / rapid heart
- ☐ blood clots legs or lungs

Respiratory
- ☐ emphysema
- ☐ asthma
- ☐ chronic obstructive disease
- ☐ CPAP / oxygen use

Gastrointestinal
- ☐ abdominal pain
- ☐ hepatitis
- ☐ peptic ulcer

Genitourinary
- ☐ kidney disease
- ☐ unable to control urine

Musculoskeletal
- ☐ muscle wasting
- ☐ osteoporosis
- ☐ arthritis

Hematological
- ☐ anemia
- ☐ bleeding disorder

Neurological
- ☐ paralysis
- ☐ tremor
- ☐ stroke
- ☐ seizures

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

Endocrine
- ☐ frequent urination
- ☐ excessive thirst

Imaging
- ☐ claustrophobia
- ☐ contrast or dye reaction
- ☐ metal implants
- ☐ pacemaker / stimulator

List your current or previous severe illnesses such as diabetes, hypertension, heart attack, cancer, etc.

_____

_____

List your previous surgery: _____

_____

_____

List your drug allergies: _____

List your medications: (If you have a medication list you may give us a copy instead of filling out the space below.)

_____

_____

_____

_____

Do you have a family history of any of the following problems?

- ☐ stroke
- ☐ heart disease
- ☐ bleeding disorder
- ☐ diabetes
- ☐ cancer
- ☐ kidney disease

Social History:

- ☐ Do you smoke cigarettes: packs per day _____; how many years have you smoked _____; year quit _____
- ☐ Do you consume alcoholic beverages: liquor _____; wine _____; beer _____; frequency _____
- ☐ Do you use recreational drugs? _____
- ☐ Have you seen another neurosurgeon, spine surgeon or neurologist for this problem? _____

Current profession: _____ Past profession if retired: _____

_____ _____ _____/_____/_____

Print name Signature Date

JPP2/18/2013