MIDWEST NEUROSURGERY & SPINE
Adult & Pediatric SPECIALISTS

PLEASE USE BLACK INK

Patient Name: ____ **D/O/B:** _____________

Reason for today's visit: ____

DO NOT LEAVE BLANK

Current problem results from: MVA date:_______ Work Comp date of injury: ______

Surgeries & Hospitalizations: (since last appt)	**Date**	**Complications**
None since last visit		

Current Medication(s):	**Dose**	**Frequency**
No changes since last visit		

Blood Thinners:_________________________________ **OR No changes since last visit**

Allergies:_______________________________________ **OR No changes since last visit**

Family History: *Please circle those conditions present in siblings, parents and grandparents*

High Blood Pressure Heart Disease Cancer Diabetes
Liver Disease Bleeding Problems Birth Defects Kidney Disease

*If yes, which family member:*____

____

Social History: *Check all that apply* ***OR*** **No changes since last visit**

Current tobacco use ____

Current alcohol use ____

Change in marital status ____

Change in employment ____

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Patient Name: ____ **D/O/B:** ____________

Review of Systems: *Please circle new/current symptoms* OR **No changes since last visit**

Weight Loss	Fevers	Balance Difficulties	Vision Changes
Hearing Changes	GERD or Ulcer	Thyroid Disease	Lung Disease
Mental Illness	Headaches	Seizures	Bleeding Problems
Leg Coordination	Diabetes	Cancer	Arm Coordination
Shortness of Breath	Skin Cancer/Disease	Bladder or Bowel Function Changes	

Musculoskeletal:

Arm Pain (If Yes – circle: Left, Right or Both)	Yes	No
Arm Weakness (If Yes – circle: Left, Right or Both)	Yes	No
Leg Pain (If Yes – circle: Left, Right or Both)	Yes	No
Leg Weakness (If Yes – circle: Left, Right or Both)	Yes	No
Lower Back Pain	Yes	No
Upper Back Pain	Yes	No
Neck Pain	Yes	No

Please list all specialists participating in your care:

Provider Name:	**Condition:**

Please circle all current health problems:

Heart Disease	Lung Disease	Diabetes	Hypertension
Seizures	Stroke or TIA	HIV	Liver Disease
GERD	Thyroid Disease	Kidney Disease	Pulmonary Embolus/Blood Clot

____ ________________________

Patient Signature **Date**