VCU Medical Center

Virginia Commonwealth University

Neurosurgery Patient Questionnaire

Date:_____ Patient Name:_____

Date of Birth:_____ Height_____ Weight_____

Address:_____

_____

Phone: (H) _____ (W)_____ (C)_____

E-mail Address:_____

Emergency Contact:_____

Relationship:_____ Phone:_____

Referring Physician:_____

Address:_____

Phone #:_____ Fax #:_____

Primary Care Physician:_____

Address:_____

Phone #:_____ Fax #:_____

Insurance co:_____**Policy/group #**_____

Present History

What is the main reason for your visit today?:_____

_____

_____

When and how did your problem start?_____

_____

_____

Describe the location of your symptoms and/or pain _____

_____

Describe your symptoms: __ burning __ numb __ stabbing __ pins __ ache __ tingling __ weakness

other:_____

Please indicate the severity of your pain on a scale from 1 to 10 ("10" being most severe, "0" if no pain)?

At Worst

0 1 2 3 4 5 6 7 8 9 10

No pain worst pain imaginable

At Best

0 1 2 3 4 5 6 7 8 9 10

No pain worst pain imaginable

Now

PATIENT NAME_____ Date of Birth _____ OVER→

0 1 2 3 4 5 6 7 8 9 10

No pain worst pain imaginable

What makes your symptoms/pain worse?_____

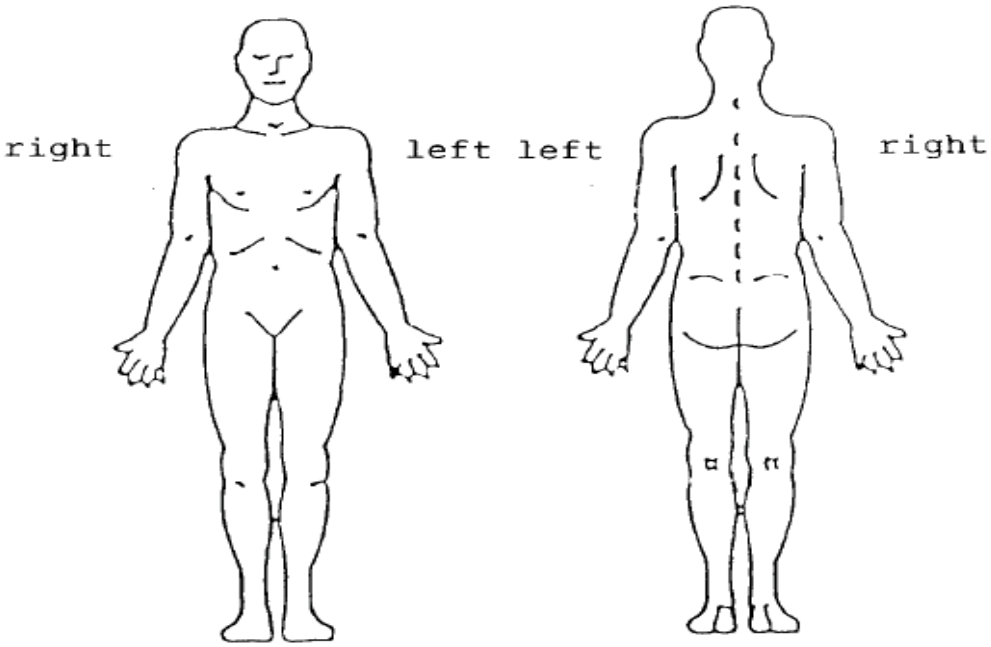
_____

What helps to relieve your symptoms (e.g. ice, heat, sitting, standing)?_____

_____

_____

IF APPLICABLE: Please mark the areas where you have pain, numbness, or other symptoms



Have you had any of the following treatments?

__ Physical therapy …duration_____ __ Traction…duration_____

__ Pain medications…. name/duration _____

__ Anti-inflammatories…. name/duration_____

__ Muscle relaxants…name/duration_____

__ Injections…please list_____

__ Other…please list_____

Please list any X-rays, CT Scans, MRIs, nerve studies, or any other tests related to your condition that you have had:_____

_____

_____

Past Medical History

(Please check all that apply to you or your family, now or in the past)

Patient	Family		Patient	Family	
____	____	High blood pressure	____	____	Stomach ulcers / upset
____	____	Diabetes	____	____	Thyroid problems
____	____	Heart disease	____	____	Cancer_____
____	____	Anemia	____	____	Arthritis
____	____	Bleeding problems	____	____	Glaucoma
____	____	Hepatitis	____	____	Seizures
____	____	Kidney disease	____	____	Stroke
____	____	TB (tuberculosis)	____	____	Migraines
____	____	Asthma	____	____	Depression/anxiety
____	____	Incontinence	____	____	Problems with surgery_____
____	____	Chronic bronchitis	____		HIV positive
____	____	Sleep Apnea	____	____	Other_____

Past Surgical History

Please List All Surgeries

Date	Surgery	Doctor / Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Work Status: __ Employed __ Unemployed __ Retired

Occupation:_____

Are you currently able to work? __YES __NO

If not working, is it due to this problem? __YES __NO When did you last work?_____

Was your current condition caused by?

_____Work related injury Date:_____ Is this a workers compensation case? __YES __NO

_____Motor vehicle accident Date_____ Is this a personal injury case? __YES __NO

Are you on Disability? __YES __NO…….. In the process of obtaining Disability? __YES __NO

Do you use tobacco?(check all that apply) __NO __YES…..

__Cigarettes __Cigars __Chew Amount_____

Do you consume alcoholic beverages? (check all that apply) __NO __YES…….

__ Beer __ Wine __ Liquor Amount_____

Have you ever been told you have a drinking problem? __YES __NO

Do you now or have you ever abused prescription drugs or other illegal drugs? __YES __NO

Please describe_____

Do you drink coffee or drinks with caffeine? __YES __NO. If so how many per day?_____

PATIENT NAME_____ Date of Birth _____ OVER→

Review of Systems

Have you ever had any of the following (Please check any that apply):

General: Any UNEXPLAINED**….** _weight loss/gain _weakness _night sweats _fevers _chills _loss of appetite _none

Skin: _Rashes _Easy bruising _other sores _yellow skin (jaundice) _none

Head: _Injury _Dizziness _Headaches _other_____ _none

Eyes: _Vision changes _cataracts _glaucoma _none

Ears: _ringing _pain _drainage _other _____ _none

Nose: _changes in sense of smell _sinusitis _other_____ _none

Throat: _sores on gums _lumps _trouble swallowing _other _____ _none

Lungs: _shortness of breath _bronchitis _pneumonia _sleep apnea _chronic cough _blood clot in lung _TB (tuberculosis) _ none

Heart: _chest pain _heart attack _blocked arteries _swelling _murmurs _irregular heart beat _trouble breathing while laying _none

GI: _acid reflux _ulcer _stomach pain _bloody or dark stools _ constipation _diarrhea _nausea _vomiting _changes in bowel habits _hepatitis _none

GU: _Change in bladder habits _bloody or dark urine _trouble voiding _unable to hold urine _sexual dysfunction _kidney stones _none

Endocrine: _diabetes _thyroid condition _none

Musculoskeletal: _broken bones _arthritis _joint pain _none

Vascular: _leg pain with walking _blood clots _none

Hematology: _free bleeding _anemia _sickle cell trait _none

Neurological: _seizures _stroke _migraines _none

Psychological: _depression _anxiety _other_____ _none

Miscellaneous: _allergy to eggs _problems with surgery _none

Other:_____

_____

Reviewed and confirmed, 4 pages (MD Signature)