TORRANCE MEMORIAL
PHYSICIAN NETWORK

NEUROSURGERY HEALTH QUESTIONNAIRE

Name: _____ **DOB** _____ **Date:** _____

MAIN SYMPTOMS

What symptoms do you feel? (pain, weakness, numbness, headache, vision difficulty, etc.) _____

_____

Where do you feel your symptoms? (neck, arm, back, leg, right side, head, etc) _____

_____

When did you first notice these symptoms? _____

How did it start? (accident, injury, spontaneous, etc) Describe onset. _____

_____

At the start, what did you feel first and where? (pain in the left leg, pain in right eye, etc.) _____

_____

PREVIOUS PROBLEMS

Have you had similar problems at any time? ☐ Yes ☐ No

If so, when? How did it get better? (surgery, physical therapy, epidural steroids, medication, rest, etc.) _____

_____

SINCE ONSET

What treatment have you had? (surgery, physical therapy, epidural steroids, medication, rest, etc.) _____

_____

If treated, where and when did you have the treatments? _____

Have you had remissions or relapses (better/worse) and when? _____

Which doctors have you seen for this problem? _____

PRESENT COURSE

Are your symptoms better, worse, same since they started? _____

Are they aggravated by sitting, standing, walking, or any activities? If so, how far can you walk, and how long can you stand?

_____

Are you having difficulty with balance, coordination, speech, vision? ☐ Yes ☐ No If so, describe _____

_____

Are you having changes in your sleep or weight patterns? ☐ Yes ☐ No If so, describe _____

_____

Are you working? ☐ Yes ☐ No If you stopped, when and why? If you restarted, when? _____

_____

What medications are you taking for this problem? _____

What tests have you had? (MRI, CAT scan, EMG, etc) _____

OTHER

What else would you like me to know about your problem? _____

_____

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GENERAL HISTORY *(PLEASE ANSWER TO THE BEST OF YOUR ABILITY. USE BACK SIDE IF NECESSARY)*

Name: _____ **DOB** _____ **Date:** _____

PAST MEDICAL HISTORY

Otherwise in good health? (any serious illness) ☐ Yes ☐ No If not, _____

Any previous surgery? ☐ Yes ☐ No If yes, _____

Any previous major fracture? ☐ Yes ☐ No If yes, _____

Alcohol use: ☐ Never ☐ Rarely ☐ Moderately ☐ Ever

Tobacco: ☐ Never ☐ Use to ☐ Smoke now: _____ Packs per day for years_____

Allergic to any medication? ☐ Yes ☐ No If yes, Penicillin, other antibiotics, Sulfa drugs, Iodine, others _____

Currently taking medication? ☐ Yes ☐ No If yes, _____

FAMILY MEDICAL HISTORY

Family history not available (adoption, for example) ☐ Yes ☐ No

Father: ☐ Living and well ☐ Poor health ☐ Deceased: Age_____ Due to _____

Mother: ☐ Living and well ☐ Poor health ☐ Deceased: Age_____ Due to _____

Siblings:_____ Total / _____ In poor health due to:_____ / _____ Deceased due to:_____

Children:_____ Total / _____ In poor health due to:_____ / _____ Deceased due to: _____

Family history of medical problems? ☐ Yes ☐ No (Please Circle): Cancer Diabetes Heart trouble High blood pressure Stroke Convulsions Suicide Mental Illness Bleeding tendency Gout or other arthritis Hereditary defects Tuberculosis

REVIEW OF SYSTEMS ESSENTIALLY UNREMARKABLE

Yes	No	System	Symptoms *(Please circle appropriate symptoms)*
☐	☐	Head/Neck	Headaches Migraines Stiffness
☐	☐	Eyes/Nose/Throat	Cataracts Glaucoma Blindness Allergies Sinusitis Impaired hearing Dizziness
☐	☐	Chest	Asthma Emphysema Difficulty breathing Pneumonia Chronic cough URl (cold) now
☐	☐	Heart	Heart attack High blood pressure Chest pain Shortness of breath Murmur
☐	☐	Abdomen	Ulcer Hepatitis Colitis Gallbladder disease Vomiting Bleeding in bowel movements
☐	☐	Genitourinary	Loss of urine Frequent urination Nighttime urination Blood in urine Kidney trouble
☐	☐	Skin	Cancer Skin disease Hives or rash Infections Abnormal skin markings
☐	☐	Tumors	Cancer of any kind (lung, breast, prostate, others) Other tumors
☐	☐	Neurological	Memory difficulty Seizures Paralysis Speech difficulty Walking difficulty Fainting
☐	☐	Psychiatric	Psychiatric care Depression
☐	☐	Hematological	Bleed or bruise easily Slow to heal Anemia Phlebitis Blood disease
☐	☐	Endocrine	Thyroid disease Hormone therapy