Main Line HealthCare
Physician Network

MAIN LINE HEALTH JEFFERSON NEUROSURGERY

DATE: _____

DOB: _____

NAME: _____

REASON FOR TODAY'S VISIT: _____

_____

When did your symptoms start? _____

MEDICAL HISTORY:

_____

_____

_____

_____

_____

_____

OPERATIONS/SURGERIES — PLEASE GIVE YEAR:

_____

_____

_____

_____

_____

_____

PHARMACY: _____ **CITY & STATE:** _____ **PHONE #:** _____

MEDICATION LIST (provide dosage):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

ALLERGIES TO DRUG, FOOD, ETC:

_____

_____

_____

REACTION:

_____

_____

_____

SEVERITY:

_____

_____

_____

SOCIAL HISTORY:

Cigarettes: ☐ Yes ☐ No: (packs per day) _____ **Former Smoker:** (Quit Year) _____

Smokeless Tobacco: ☐ Yes ☐ No

Alcohol: ☐ Yes ☐ No **Type:** ☐ Beer ☐ Wine ☐ Liquor **How Often:** ☐ Daily ☐ Socially ☐ Occasionally

FAMILY HISTORY:

Mother: ☐ Alive ☐ Deceased Age: _____ Illness or cause of death: _____

Father: ☐ Alive ☐ Deceased Age: _____ Illness or cause of death: _____

Brother: ☐ Alive ☐ Deceased Age: _____ Illness or cause of death: _____

Sister: ☐ Alive ☐ Deceased Age: _____ Illness or cause of death: _____

NAME:_____ **DOB:**_____

NEURO MEDICAL HISTORY:

Alzheimer's Disease	Y ☐ / N ☐	Disc Problem — Cervical	Y ☐ / N ☐	Headache	Y ☐ / N ☐
Aneurysm	Y ☐ / N ☐	Disc Problem — Lumbar	Y ☐ / N ☐	Lower Back Pain	Y ☐ / N ☐
Carotid Disease	Y ☐ / N ☐	Disc Problem — Thoracic	Y ☐ / N ☐	Memory Loss	Y ☐ / N ☐
Cerebral Palsy	Y ☐ / N ☐	Neck Pain	Y ☐ / N ☐	Neuropathy	Y ☐ / N ☐
Concussion	Y ☐ / N ☐	Neurofibromatosis	Y ☐ / N ☐	Seizure	Y ☐ / N ☐
Difficulty Walking	Y ☐ / N ☐	Head Injury	Y ☐ / N ☐	Spinal Headache	Y ☐ / N ☐

REVIEWS OF SYSTEMS-PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH:

CONSTITUTION:

Chills	Y ☐ / N ☐
Fatigue	Y ☐ / N ☐
Fever	Y ☐ / N ☐
Weight Change	Y ☐ / N ☐

GI:

Abdominal Swelling	Y ☐ / N ☐
Abdominal Pain	Y ☐ / N ☐
Blood in Stool	Y ☐ / N ☐
Constipation	Y ☐ / N ☐
Diarrhea	Y ☐ / N ☐
Nausea	Y ☐ / N ☐

MUSCULOSKELETAL:

Joint Pain	Y ☐ / N ☐
Back Pain	Y ☐ / N ☐
Gait Problem	Y ☐ / N ☐
Muscle	Y ☐ / N ☐
Neck Pain	Y ☐ / N ☐
Neck Stiffness	Y ☐ / N ☐

ENT:

Facial Swelling	Y ☐ / N ☐
Hearing Loss	Y ☐ / N ☐
Nosebleeds	Y ☐ / N ☐
Voice Change	Y ☐ / N ☐
Excessive Thirst	Y ☐ / N ☐
Sensitivity To Light	Y ☐ / N ☐
Visual Disturbances	Y ☐ / N ☐

ENDOCRINE:

Cold Intolerance	Y ☐ / N ☐
Heat Intolerance	Y ☐ / N ☐
Excessive Thirst	Y ☐ / N ☐
Excessive Appetite	Y ☐ / N ☐

NEUROLOGICAL:

Headaches	Y ☐ / N ☐
Numbness	Y ☐ / N ☐
Weakness	Y ☐ / N ☐
Seizures	Y ☐ / N ☐
Speech Difficulty	Y ☐ / N ☐
Dizziness	Y ☐ / N ☐

RESPIRATORY:

Sleep Apnea	Y ☐ / N ☐
Chest Tightness	Y ☐ / N ☐
Cough	Y ☐ / N ☐
Shortness of Breath	Y ☐ / N ☐
Wheezing	Y ☐ / N ☐

GENITOURINARY:

Urine Decreased	Y ☐ / N ☐
Difficulty Urinating	Y ☐ / N ☐
Painful Urinating	Y ☐ / N ☐
Bloody Urine	Y ☐ / N ☐

HEMATOLOGIC:

Bruise Easily	Y ☐ / N ☐

CARDIOVASCULAR:

Chest Pain	Y ☐ / N ☐
Leg Swelling	Y ☐ / N ☐
Heart Palpitations	Y ☐ / N ☐

ALLERGIC/IMMUNOLOGICAL:

Environmental Allergies	Y ☐ / N ☐
Food Allergies	Y ☐ / N ☐

PSYCHIATRIC:

Nervous	Y ☐ / N ☐
Anxious	Y ☐ / N ☐
Sad or Depressed	Y ☐ / N ☐
Sleep Disturbance	Y ☐ / N ☐