MUNSON NEUROSURGERY
PATIENT MEDICAL HISTORY

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Patient Name_____Today's Date_____

Birthdate_____ Age_____ Male____ Female____ Social Security Number_____

Height_____ Weight_____ Marital Status_____ Email Address_____

Home phone_____Work_____Cell_____

Street Address_____City/State/ZipCode_____

Occupation_____Employer_____

What is the reason for your visit?_____

Who is the Doctor that sent you to us?_____

Who is your primary Doctor?_____

Allergies_____

Name of Pharmacy and Location:_____

Current Medications (Including Over the Counter Vitamins and Supplements) or Attach List

1._____ 11._____

2._____ 12._____

3._____ 13._____

4._____ 14._____

5._____ 15._____

6._____ 16._____

7._____ 17._____

8._____ 18._____

9._____ 19._____

10._____ 20._____

PAST MEDICAL HISTORY: Please mark the box if you (self) have or had any of the following conditions

	NO	YES		NO	YES
Epilepsy	☐	☐	Diabetes	☐	☐
Seizures	☐	☐	Heart Disease	☐	☐
Liver Disease	☐	☐	Eye Disease	☐	☐
Hepatitis	☐	☐	High Blood Pressure	☐	☐
Stomach Ulcer	☐	☐	Stroke	☐	☐
Other Diagnosis_____			Cancer	☐	☐
_____			Type of Cancer_____		

SURGERIES AND HOSPITALIZATIONS

Surgery	Year	Hospitalizations

FAMILY HISTORY

Relation	Age	State of Health	Age of Death	Cause of Death
Father				
Mother				
Brother				
Sisters				

HEALTH HABITS

- ☐ Caffeine _____cups per day
- ☐ Alcohol _____ounces per day
- ☐ Drugs_____
- ☐ Other_____
- ☐ Smoke _____pack per day ☐ Smokeless tobacco ☐ NON-Smoker ☐ Former ____quit date

Have you fallen in the past year? _____ How many times? _____ Was there injury? _____

SYMPTOMS: Please check the box all symptoms you currently have or had in the PAST YEAR

General

- ☐ No history of problems
- ☐ Hand ___Left ___Right
- ☐ Anesthesia Complications
- ☐ Fever
- ☐ Loss of weight

Endocrine

- ☐ No history of problems
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Breast Discharge

Gastrointestinal

- ☐ No history of problems
- ☐ Vomiting Blood
- ☐ Nausea
- ☐ Vomiting
- ☐ Other_____

Eye

- ☐ No history of problems
- ☐ Double Vision
- ☐ Vision Flashes
- ☐ Other_____

Respiratory

- ☐ No history of problems
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Sleep Apnea

Gentio-Urinary

- ☐ No history of problems
- ☐ Burning/Painful Urination
- ☐ Lack of Bladder Control
- ☐ Other_____

Ears/Nose/Throat

- ☐ No history of problems
- ☐ Bleeding Gums
- ☐ Loss of Hearing
- ☐ Temporary/partial blindness
- ☐ Difficulty swallowing
- ☐ Nose Bleeds

Cardiovascular

- ☐ No history of problems
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Other_____

Skin

- ☐ No history of problems
- ☐ Bruise Easily
- ☐ Sore that won't heal
- ☐ Other_____