

NEUROLOGICAL SURGERY ASSOCIATES, P.C.

Please complete (print) and bring with you to your appointment. Thank you.

NAME _____ **OCCUPATION:** _____

WEIGHT _____ **HEIGHT** _____ **AGE** _____

Please state your major complaint (why you are coming to see the doctor) as briefly as possible:

PRESENT MEDICATIONS: (Please attach additional sheet if necessary)

<i>NAME OF MEDICATION</i>	<i>DOSAGE AMOUNT</i>	<i>FREQUENCY</i>

DRUG ALLERGIES: _____

MEDICAL ILLNESSES: (ex: hypertension, mitral valve prolapse, diabetes)

PRIOR SURGERIES: (Please attach additional sheet if necessary)

<i>TYPE OF SURGERY</i>	<i>DATE OF SURGERY (APPROXIMATELY)</i>

PLEASE ANSWER THE FOLLOWING RELATING TO YOUR MEDICAL CONDITION: (Please Circle)

Dizziness	Yes	No	Recent Urinary			Diabetes	Yes	No
Fainting	Yes	No	Tract Infection	Yes	No	History of Hepatitis	Yes	No
Chronic Headaches	Yes	No	Hypertension	Yes	No	Allergic Sinusitis	Yes	No
Blurred Vision	Yes	No	History of MVP	Yes	No	Arm Weakness	Yes	No
Double Vision	Yes	No	Shortness of Breath	Yes	No	Leg Weakness	Yes	No
Ringing in Ears	Yes	No	Asthma	Yes	No	Numbness/Tingling		
Difficulty Swallowing	Yes	No	Emphysema	Yes	No	Upper Extremities	Yes	No
Bleeding Ulcers	Yes	No	History of Cancer	Yes	No	Numbness/Tingling		
						Lower Extremities	Yes	No

FAMILY HISTORY (Pertinent to present illness): _____

SOCIAL HISTORY: Alcohol: Yes No Occasional Tobacco: Yes No

SIGNATURE: _____ **DATE:** _____