CSNA
neurosurgery, neurology
& pain management

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Date: ___/___/___
Name: ____________________________ Age: ______ Date of Birth: ___/___/___ Sex: M / F
Referring MD: ______________ Primary MD: ______________ Height: ____ Weight: ____ Right / Left Handed
How did you hear about us? ☐ Online ☐Physician Referral ☐ Friend/relative ☐ Other: ___________
Please list conditions / diseases you wish to have checked at this examination:
____
____

MEDICATIONS: (Please list medications & dosages)	

ANY BLOOD THINNERS: Coumadin Plavix Aspirin Other:__________________
ALLERGIES: (Please list any allergies to medications) ____

CONDITIONS: (Please mark any conditions you have or had in the past)

- ☐ AIDS / HIV
- ☐ Alcohol problems
- ☐ Appendicitis
- ☐ Arm pain
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Bleeding Disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Cancer
- ☐ Carpal Tunnel Syndrome
- ☐ Chemical Dependency
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Disease
- ☐ Hernia
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low back pain
- ☐ Neck pain
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Prostate problem
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Sexually Transmitted Disease
- ☐ Stroke / TIA
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers

MAJOR ILLNESSES, SURGERIES, or HOSPITALIZATIONS:
____ Year: ______
____ Year: ______
____ Year: ______
____ Year: ______
____ Year: ______
____ Year: ______

Your occupation: ____________________ Marital Status: _________________

OCCUPATIONAL CONCERNS:
Have you filed a Work Injury report with your employer?
YES / NO
Date of injury: ___/___/___

Is there a lawsuit planned relating to the current medical problem?
YES / NO

HEALTH HABITS

Tobacco	Yes / No	Packs per day: ______
Alcohol	Yes / No	Drinks per day: ______
Recreational Drugs	Yes / No	

FAMILY HISTORY
Father – Age: ___ Condition of health: _________ Desceased at age: ___ Cause of death: __________
Mother – Age: ___ Condition of health: _________ Desceased at age: ___ Cause of death: __________
Any significant illnesses in the family: ____

Constitutional Symptoms: (Please mark any symptoms that you may have)

GENERAL
- ☐ Fever
- ☐ Fatigue
- ☐ Loss of appetite
- ☐ Significant weight loss

OPHTHALMOLOGY
- ☐ Vision loss
- ☐ Blurring of vision
- ☐ Double vision

GASTROENTEROLOGY
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in stool

DERMATOLOGY
- ☐ Itching
- ☐ Redness
- ☐ Lumps
- ☐ Rash
- ☐ Skin cancer

ENDOCRINOLOGY
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Temperature intolerance
- ☐ Lactation

NEUROLOGY
- ☐ Headache
- ☐ Memory problems
- ☐ Tremors
- ☐ Balance difficulty
- ☐ Numbness
- ☐ Weakness
- ☐ Speech problems
- ☐ Dizziness
- ☐ Seizures

HEMATOLOGY
- ☐ History of transfusion
- ☐ Easy bruising

ENT / RESPIRATORY
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Cold and cough
- ☐ Change in voice
- ☐ Difficulty swallowing

CARDIOLOGY
- ☐ Chest pain
- ☐ Palpitations / irregular heartbeat
- ☐ Leg swelling
- ☐ History of heart attack
- ☐ Atrial fibrillation

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle aches

PSYCHOLOGY
- ☐ Anxiety
- ☐ Depression
- ☐ Sleep disturbances
- ☐ Hyperactivity
- ☐ Attention deficit

GENITOURINARY
- ☐ Difficulty urinating
- ☐ Urinary urgency
- ☐ Increased urinary frequency
- ☐ Urinary incontinence

NOTES:

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Please list the physicians to whom you would like for us to send a report:

- ______________________________ • ______________________________
- ______________________________ • ______________________________

Patient signature: ____