

Patient Name: _____

Birth date: _____ Date: _____

Past Medical History (please put x in all that apply)

	Y	N		Y	N		Y	N
Aneurysm Disease			Spondylosis (arthritis)			Kidney Disease		
Cranial Tumor			Stroke or TIA			Liver/Hepatitis Disease		
Dementia			Blood Disease			Lung Disease		
Disc Disease			Cancer			Pancreatitis		
Head Trauma			Diabetes			Peptic Ulcer Disease		
Migraine Headaches			DVT			Psychiatric/Behavioral Problems		
Non-migraine Headaches			Gallbladder/Biliary Disease			Pulmonary Embolism		
Paralytic Syndrome			Heart Disease			Rheumatoid Arthritis		
Parkinson's Disease			High Blood Pressure			Superficial Disease		
Seizures			HIV/AIDS			Thyroid Disease		
Spinal Tumor			High Cholesterol					

Other Past Medical History: _____

Surgical History (please put x in all that apply)

	Y	N		Y	N
Adverse Reaction to Anesthesia			Cervical Spine Surgery		
Craniotomy			Thoracic Spinal Surgery		
DBS Placement			Lumbar Surgery		
Endarterectomy			Epilepsy Surgery		
Intrathecal Pump			Stereotactic Radiosurgery		
Spinal Cord Stimulator			Microvascular Decompression		
Brain Radiation			Trigeminal Neuralgia Surgery		
Ventricular Shunt			Appendectomy		
VNS Placement			Tonsillectomy/Adenoidectomy		
Thyroid Surgery			Hysterectomy		
Pituitary Surgery			Cholecystectomy (gallbladder removal)		
CABG (heart surgery)			Prostate Surgery		
Coronary Artery Stent			Fracture Surgery		

Other Surgical History: _____

Patient Name: _____

Birth date: _____ Date: _____

Family Medical History (please put x in all that apply)

	Adverse Reaction to Anesthesia	Aneurysm	Asthma	Bleeding Disorder	Brain Tumor	Cancer, Other	Dementia	Diabetes	Heart Disease	Hypertension	Mental Illness	Migraine	Parkinson's Disease	Peptic Ulcer Disease	Seizures	Stroke	Tuberculosis	Vascular Malformations
Mother																		
Father																		
Maternal Grandmother																		
Maternal Grandfather																		
Paternal Grandmother																		
Paternal Grandfather																		
Sisters																		
Brothers																		
Other																		
Unknown/None																		

Social History

Use of Tobacco Products: Y or N Packs/Day: _____ **Smokeless Tobacco:** Y or N
 Number of years: _____ Quit date: _____
 Ready to quit: Y or N

Alcohol Use: Y or N
 Number of drinks per week:
 _____ Glasses of wine _____ Cans of Beer
 _____ Shots of liquor _____ Drinks containing 0.5 oz of alcohol

Drug Use: Y or N
 Per week: _____ Type: _____