University of Pittsburgh Physicians
Department of Neurological Surgery

Patient Name:_____

Birth date: _____ Date:_____

Pharmacy Name/Location/Phone number: _____

_____

Family Physician Name: _____Phone:_____

Address:_____

_____

Referring Physician Name: _____Phone:_____

Address: _____

_____

First Emergency Contact: _____ Relationship: _____

Home/cell phone: _____ Work phone: _____

Second Emergency Contact: _____ Relationship: _____

Home/cell phone: _____ Work phone: _____

Personal Designation form on file (Y/N): _____ If yes, name of person designated:_____

Patient's Occupation: _____ Employer: _____

Full-time or Part-time:_____

Patient's email address: _____

Active MyUPMC account (Y/N): _____

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Insurance information

Primary Insurance: _____ ID: _____

Group: _____ Copayment: _____

Secondary Insurance: _____ ID: _____

Group: _____ Copayment: _____

If applicable:

Auto: _____ Workers compensation: _____ Date of Injury: _____ Claim #: _____

Insurance Name (auto or workers compensation): _____

Address: _____

Contact agent and phone number: _____

Attorney name and phone number: _____

Attorney Address: _____

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Medications (include over the counter medications, vitamins and supplements)

Medication Name	Dosage

Allergies (drug, food, or environmental)

Allergic reaction to:	Reaction

Allergic to:	Y	Reaction	Allergic to:	Y	Reaction
Shellfish			MRI contrast (dye)		
Iodine			CT contrast (dye)		
Latex			IVP contrast (dye)		
			Angiogram contrast (dye)		

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Patient Name:_____

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Reason for today's visit:_____

Patient reported: Height: _____ ft _____in Weight: _____lbs

Review of Systems (please put x in all that apply)

I have no current symptoms: _____

	Y		Y		Y		Y
Fever		Shortness of Breath		Joint Pain		Seizures	
Weight Gain		Wheezing		Joint Swelling		Dizziness	
Weight Loss		Chronic Cough		Falls		Lightheadedness	
Malaise/Fatigue		Bloody Sputum		Leg/Arm Pain		Leg/Arm Weakness	
Night Sweats				Neck Pain		Numbness/Tingling	
Weakness		Chest Pain		Lower Back Pain		Speech Difficulty	
Decreased Appetite		Leg Cramping		Thoracic Pain		Disturbances in Coordination	
		Leg Swelling		Difficulty Walking			
Headaches				Muscle Cramps		Confusion	
Hearing Loss		Difficulty Swallowing				Disorientation	
Tinnitus		Nausea		Rash		Facial Spasm	
Throat Pain		Abdominal Pain		Skin Lesion		Facial Numbness	
Ear Pain		Blood in Stool		Mole Change		Facial Weakness	
Loose Teeth		Bowel Incontinence				Loss of Balance	
Facial Pain				Lumps in Neck		Loss of Smell	
		Bladder Incontinence		Lumps in Groin		Loss of Taste	
Blindness		Urgency		Easily Bruises/Bleeds			
Blurred Vision		Frequency				Depression	
Double Vision		Impotence		Frequent Infections		Nervous/Anxious	
Eye Pain		Pain when Urinating		Environmental Allergies		Memory Loss	
Loss of Vision		Urinary Burning					
				Cold Intolerance			
Nipple Discharge		Difficulty Urinating		Heat Intolerance			
		Loss of Menstrual Cycle		Excessive Thirst			

Other symptoms: _____

_____

_____

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

	Y		Y		Y
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		Y
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: _____

_____

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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																		

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Social History

Smoking Tobacco Use:

	Y		Y
Never a smoker		Passive Smoke Exposure	
Former Smoker			
Current Every Day Smoker		Current Some Day Smoker	
Heavy Tobacco Smoker		Light Tobacco Smoker	

Packs/Day: _____ Start date:_____ End date:_____

Type: Cigarettes ____ Pipe____ Cigars____

Ready to quit: Y or N

Smokeless Tobacco:

	Y		Y		Y
Never used		Former user		Current user	

Number of years: _____ Start date_____ 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

Use per week:___ _____ Type of drug: _____