Dr. William Caton, Dr. Haig Minassian, Dr. Ian B. Ross
Neurosurgery
Patient Evaluation and Management Services

Date:_____

Name: _____DOB:_____ Gender: (F M)

Referring Physician:_____FamilyPhysician_____

Other treating physicians in the past five years:

Name	**Phone**
1.	
2	
3.	
4.	

What is the current problem for which you are here? (Chief Complaint)

When did it start? **If injury, date**

Are you getting worse?

Physician Notes on CC and HPI

Please specify symptoms: (HPI) ● **location** ● **quality** ● **severity** ● **duration** ● **timing** ● **context** ● **modifying factors**
● **status of 3 chronic or inactive conditions** ● **associated signs and symptoms**

Physician Signature

Dr. William Caton, Dr. Haig Minassian, Dr. Ian B. Ross
Neurosurgery
Patient Evaluation and Management Services

Name: _____ **Date:** _____

Review of Systems: **Do you currently have any of these symptoms?**

Please check the symptoms that best describe your condition.

•General
□ Chills
□ Fatigue
□ Fever
□ Night Sweats
□ Weight Gain
□ Weight Loss

• Skin
□ Dryness
□ Excessive Sweating
□ Rash
□ Ulcer

• HEENT
□ Blurred Vision
□ Double Vision
□ Glaucoma
□ Visual Loss
□ Hearing Loss
□ Decreased Hearing
□ Tinnitus
□ Spinning Sensation
□ Vertigo
□ Sleep Apnea
□ Hoarseness
□ Decreased Sense of Smell
□ Facial Numbness/Tingling
□ Decreased Sense of Taste

•Neck
□ Neck Mass
□ Neck Pain
□ Neck Spasms
□ Neck Stiffness
□ Neck Swelling

• Respiratory
□ Chronic Cough
□ Difficulty Breathing
□ Wheezing

• Breast
□ Breast Mass
□ Nipple Discharge

• Cardiovascular
□ Chest Pain
□ Difficulty Breathing w/exertion
□ Irregular Heart Beats
□ Palpitations
□ Shortness of Breath

• Gastrointestinal
□ Abdominal Mass
□ Abdominal Pain
□ Bloody Stools
□ Constipation
□ Diarrhea
□ Difficulty Swallowing
□ Hernia
□ Jaundice
□ Nausea
□ Vomiting

• Genitourinary
□ Any type of Sexual Dysfunction
□ Dark or Discolored Urine
□ Difficulty Start/End Urine Stream
□ Incontinence
□ Loss of Sensation/Genitals
□ Painful Urination

• Musculoskeletal
□ Abnormal arm/leg feelings
□ Arm/Leg Weakness
□ Back Pain
□ Joint Pain
□ Loss of control arm/leg
□ Loss of Sensation
□ Muscle Atrophy
□ Muscle Cramps
□ Muscle Weakness
□ Swelling of Extremities

• Neurological
□ Decreased Memory
□ Difficulty Speaking
□ Dizziness
□ Droopy Face or eye
□ Headaches
□ Poor Coordination
□ Loss of Consciousness
□ Numbness
□ Seizures
□ Slurred Speech
□ Spinning Sensation
□ Tremor
□ Trouble Walking
□ Weakness
□ Extremity Weakness
□ Muscle Twitching
□ Tingling

• Psychiatric
□ Anxiety
□ Depression
□ Disorientation
□ Euphoria
□ Hallucinations
□ Panic Attacks
□ Personality Changes

• Endocrine
□ Appetite Changes
□ Cold Intolerance
□ Excessive Thirst
□ Hair Changes
□ Heat Intolerance

• Hematology
□ Abnormal Bleeding
□ Easy Bruising
□ Nose Bleed

Explanation

Dr. William Caton, Dr. Haig Minassian, Dr. Ian B. Ross
Neurosurgery
Patient Evaluation and Management Services

Name: _____Date:_____

PAST MEDICAL HISTORY

• Please list any prior major illnesses or injuries including Cancer, High blood pressure, Diabetes, Ulcers, Kidney disease, Heart disease or Lung disease.

Date of last Mammogram:_____ Date of last Pap Smear:_____
Date of last Colonoscopy/Flexible Sigmoidoscopy:_____
Allergies to medications, anesthetics or X-Ray dyes? □Yes □ No Which_____
Any recent immunization? □ Yes □ No

FAMILY HISTORY:

	Alive	Dead	Ages	Age of death Cause of death	Other significant diseases in the family
Father					
Mother					
Sibling(s)					
Children					

SOCIAL HISTORY: Please circle one with the ( ).

Do you currently smoke? (Y N) If yes, _____Pack(s)/day. How long?_____

Did you previously smoke? (Y N) If yes, _____Pack(s)/day. How long?_____

How often do you drink alcoholic beverages? (Never - Occasionally - Frequently)

Have you abused any drug? (Y N) (Cocaine Crack LSD Marijuana Heroin Prescription drug Recreational drug)

Education: (Lower than Grade school - Grade school - Middle school - High school - College - Graduate school)

Marital Status: (Single - Married - Widow(er) - Divorced)

Currently employed: (Y N Retired) If yes, Occupation:_____

Is there a lawsuit planned relating to your medical problem/injury? (Y N)

If yes, against whom?_____ Attorney: _____

Worker's Compensation case? (Y N) Employer: _____

Have you recently traveled out of the country? □Yes □ No Where_____

Dr. William Caton, Dr. Haig Minassian, Dr. Ian B. Ross
Neurosurgery
Patient Evaluation and Management Services

Name:_____Date:_____

MEDICATION: Please list your current medications

Medications	Dosage

PAST SURGICAL HISTORY: Please list any recent hospitalizations and surgeries (past 5 years)

Event	Date

Have you had any recent infections? □Yes □ No
Explain: _____

****My signature signifies that I have read, answered, and understand the above information.****

Patient/Guardian signature: _____Date:_____

PHYSICIAN NOTES ON PMFSHistory

Physician's signature: **Date:**