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

1 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

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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 Smell

•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
- □ Difficulty with Erection
- □ Frequent Urination
- □ Hesitant Urination
- □ Impotence
- □ Incontinence
- □ Loss of Sensation/Genitals
- □ Nocturia
- □ 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
- □ 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

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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 Colonoscopy/Flexible Sigmoidoscopy:_____
Allergies to medications, anesthetics or X-Ray dyes? □Yes □ No
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) 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_____

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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:**

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