

**PATIENT HEALTH HISTORY  
UNITED NEUROSURGERY ASSOCIATES**

Physicians:

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Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Chief Complaint**

Reason for today's visit? \_\_\_\_\_

**Current problem is the result of a(n): check all that apply**

- Car Accident     Work Accident     Accident     In Litigation     Other \_\_\_\_\_

**Referral Data**

Name of Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Primary Physician: \_\_\_\_\_

Address: \_\_\_\_\_

**Past History**

Please list any prior illnesses and / or injuries:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Surgeries/Hospitalizations	Year	Hospital	Complications

Have you ever had problems with anesthesia?     Yes     No

Current Prescribed Medication(s)	Dose	Frequency

Current Over the Counter or Herbal Medication(s)	Dose	Frequency

**ALLERGIES TO MEDICATIONS:**

  
  

Patient Name: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_

Have you had a MRI?  Yes  No Have you had a CAT scan?  Yes  No

Are you Claustrophobic?  Yes  No

MRI or CAT Scan History	Date	Place	Area scanned

Family Member	Alive	Deceased	Age	Health Status or Cause of Death
Father	A	D		
Mother	A	D		
Sister / Brother	A	D		
Sister / Brother	A	D		
Sister / Brother	A	D		
Sister / Brother	A	D		

**Social History**

Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Do you have children?  Yes  No How many? \_\_\_\_\_

Do you live alone?  Yes  No Who lives with you? \_\_\_\_\_

Do you smoke?  Yes, I've smoked \_\_\_\_\_ packs of cigarettes per day for \_\_\_\_\_ years.

Yes, I smoke cigars or a pipe.

No, I have never smoked.

No, I quit \_\_\_\_\_ years ago. At that time I was smoking \_\_\_\_\_ packs per day for \_\_\_\_\_ years.

Do you drink alcohol?  No, never (or rarely)  No, but I used to

Yes  Daily  1 or more times a week  1 or more times a month

Are you at risk for AIDS (e.g. sexual orientation, drug abuse, previous blood transfusion)?

No  Yes, please explain: \_\_\_\_\_

**Review of Systems**

Are you currently, or have you had, problems with:

Constitutional

Fever

Weight Loss

Excessive fatigue

Night Sweats

If, yes, how often? \_\_\_\_\_

Circle One

Yes No

Yes No

Yes No

Yes No

Patient Name: \_\_\_\_\_



Patient Name: \_\_\_\_\_

#### Genitourinary

Urinary Tract Infections	Yes	No
Painful Urination	Yes	No
Blood in Your Urine	Yes	No
Difficulty Starting or Stopping Stream	Yes	No
Incontinence	Yes	No
Kidney Stones	Yes	No
Prostate Cancer (Males)	Yes	No
Endometriosis (Females)	Yes	No
Uterine or Cervical Cancer (Females)	Yes	No

#### Musculoskeletal

Broken Bone - List: _____	Yes	No
Arm or Leg Weakness	Yes	No
Back Pain	Yes	No
Arm or Leg Pain	Yes	No
Joint Pain or Swelling	Yes	No
Arthritis	Yes	No
Do you have implants (i.e. artificial Knee, Hip)	Yes	No

#### Integumentary

Skin Disease	Yes	No
Skin Cancer	Yes	No
Breast Pain, Tenderness or Swelling (Female)	Yes	No
Nipple Discharge (Females)	Yes	No
Date and Result of Last Mammogram (Females)	Yes	No

#### Neurological

Fainting Spells or "Blacking Out"	Yes	No
Seizures	Yes	No
Problems with Your Memory	Yes	No
Disorientation	Yes	No
Difficulty with Your Speech	Yes	No
Inability to Concentrate	Yes	No
Double or Blurred Vision	Yes	No
Face Weakness	Yes	No
Coordination in Arm and / or Legs	Yes	No

#### Psychiatric

Anxiety	Yes	No
Depression	Yes	No
Other Psychiatric Disorder / Treatment: _____	Yes	No

#### Endocrine

Diabetes	Yes	No
Thyroid Disease	Yes	No
Increased Appetite	Yes	No
Excessive Thirst or Urination	Yes	No
Hormone Problems	Yes	No

