PATIENT HEALTH HISTORY
UNITED NEUROSURGERY ASSOCIATES
Nasseff Specialty Center
225 North Smith Avenue, #200
Saint Paul, Minnesota 55102
Phone 651-241-6550

Physicians:
- ☐ Mary E. Dunn, MD
- ☐ Richard S. Gregroy, MD
- ☐ Jerone D. Kennedy, MD
- ☐ Margaret A. Wallenfriedman, MD
- ☐ Teresa Armenta, CNP
- ☐ Linda Hadden, CNP
- ☐ Penny Hodges-Goetz, CNP

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	Circle One	
Fever	Yes	No
Weight Loss	Yes	No
Excessive fatigue	Yes	No
Night Sweats	Yes	No

If, yes, how often? ____

Patient Name: ____

Eyes	Circle One	
Wear Glasses - Date of Last Exam: __________________________	Yes	No
Infections	Yes	No
Injuries	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No

Ear, Nose, Throat and Mouth		
Wear Hearing Aids - Date of Last Exam: _____________________	Yes	No
Hearing Loss	Yes	No
Ear Pain	Yes	No
Ear Infections	Yes	No
Ringing in Ears Circle: Left Right Both	Yes	No
Balance Disturbance (e.g., Vertigo, Spinning)	Yes	No
Nosebleeds	Yes	No
Nasal Congestion	Yes	No
Nasal Drainage - Amount ________ Color _____________	Yes	No
Inability to Smell	Yes	No
Sinus Problems	Yes	No
Sinus Headaches	Yes	No
Sore Throats	Yes	No
Mouth Sores	Yes	No

Cardiovascular		
Chest Pain or Angina - Date of Last EKG: ________________	Yes	No
High Blood Pressure	Yes	No
Irregular Pulse	Yes	No
Heart Murmur	Yes	No
High Cholesterol	Yes	No
Swelling in Feet or Hands	Yes	No
Leg Pain While Walking	Yes	No
Do you have a pacemaker	Yes	No

Respiratory		
Asthma	Yes	No
Chronic Cough	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Lung Cancer	Yes	No
Bloody Sputum	Yes	No
Date of Last Chest X-ray: ___________________________		

Gastrointestinal		
Indigestion or Pain with Eating	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Blood in Your Vomit	Yes	No
Liver Disease	Yes	No
Jaundice	Yes	No
Abdominal Pain	Yes	No
Change in Your Bowel Habits	Yes	No
Ulcers or Gastritis	Yes	No
Colon Cancer	Yes	No

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

Patient Name: ____

Hematologic / Lymphatic

	Yes	No
Anemia	Yes	No
Hemophilia	Yes	No
Bleeding Tendencies	Yes	No
Persistent Swollen Glands or Lymph Nodes	Yes	No
Blood Transfusion		
If yes, when? _______________________________		

Allergic / Immunologic

	Yes	No
Food Allergies	Yes	No
Inhalant (nasal) Allergies	Yes	No
Immunologic Disorders	Yes	No

The above information is accurate to the best of my knowledge.

_________________________________ ______________
Patient Signature Date

Neurosurgeon to sign after patient exam.

_________________________________ ______________
Neurosurgeon's Signature Date

I have reviewed the above information with the patient.

_________________________________ ______________
Neurosurgeon's Signature Date

I have reviewed the above information with the patient.

_________________________________ ______________
Neurosurgeon's Signature Date

I have reviewed the above information with the patient.

_________________________________ ______________
Neurosurgeon's Signature Date

Revised 10/06