ROCKY MOUNTAIN
NEUROSURGERY

PATIENT HEALTH HISTORY FORM

All information is treated as strictly confidential. The more fully you complete this form, the better we will be able to diagnose and treat you.

Patient Name _____ DOB _____/_____/____ Age _____

Gender: ☐Female ☐Male Height _____ Weight _____ ☐Right or ☐Left handed

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

EMPLOYMENT INFORMATION

Current work status: ☐Full time ☐Part time ☐Unemployed ☐Self Employed ☐Disabled ☐Retired

Employer Name _____ Job Title _____

REFERRING PHYSICIAN

Primary Care Physician_____ Phone Number _____

Address_____City_____State_____Zip_____

Referring Physician_____ Phone Number _____

Address_____City_____State_____Zip_____

ILLNESS/INJURY INFORMATION

Chief Complaint or Problem _____

Area of Body: ☐Head ☐Neck ☐Back ☐Other _____

Duration of Problem? _____ How did symptoms start? ☐suddenly ☐gradually ☐chronic

Is problem related to an injury? ☐Yes ☐ No If yes, is injury related to? ☐Auto ☐Work

If injury related, date of injury_____/_____/_____ Claim # _____

Adjuster Name _____ Adjuster Phone # _____ Adjuster Fax # _____

Have you seen other Physicians for this problem? ☐ Yes ☐No If yes, Who? _____

Please check and include last of date of treatment for any of the following (mm/yyyy): ☐None

☐MRI Date ___/____ Type_____

☐CT Date ___/____ Type_____

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☐X-Rays Date ___/____ Type_____

☐Discogram Date ___/____ Type_____

☐Injection Date ___/____ Type_____

☐EMG Date ___/____ ☐Upper Extremity ☐Lower Extremity

☐PT Date ___/____ Facility_____

☐Chiropractic Date ___/____ Facility_____

☐Pain Clinic Date ___/____ Facility_____

PAST SURGICAL HISTORY (list any **surgery** you have had with the approximate year (yyyy): ☐ None

☐Back Surgery Year _____ Surgical Procedure _____

☐Back Surgery Year _____ Surgical Procedure _____

☐Neck Surgery Year _____ Surgical Procedure _____

☐Neck Surgery Year _____ Surgical Procedure _____

☐Brain Surgery Year _____ Surgical Procedure _____

☐Brain Surgery Year _____ Surgical Procedure _____

☐Other Surgery Year _____ Surgical Procedure _____

☐Other Surgery Year _____ Surgical Procedure _____

MEDICATIONS (List all medications you are currently taking including herbal and over the counter) ☐None

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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ALLERGIES ☐None

Medications you are allergic to: Other allergies (food, seasonal, etc…)

_____ _____

_____ _____

_____ _____

Are you allergic to? ☐Adhesive Tape ☐Latex ☐MRI Contrast (gadolinium) ☐CT Contrast (iodine)

SOCIAL HISTORY

Have you ever used tobacco in any form? ☐Yes ☐No If yes, please state when you quit _____

Have you ever used alcohol in any form? ☐Yes ☐No If yes, please list type and how much per week _____

_____

Have you ever used any other recreational substances? ☐Yes ☐No If yes, please list type and how much per week _____

MEDICAL HISTORY (Please put a check next to the disease below if you currently have, or have been diagnosed in the past)

☐Allergies (Seasonal)	☐Chron's Disease	☐Hypertension	☐Renal Disease
☐Angina	☐Depression	☐Irritable Bowel Syndrome	☐Seizure Disorder
☐Arthritis	☐Diabetes	☐Liver Disease	☐Stroke (CVA)
☐Asthma	☐Gallbladder Disease	☐Migraine Headaches	☐Substance Abuse
☐Atrial Fibrillation	☐GERD	☐Myocardial Infarction	☐Thyroid Disease
☐Blood Clots	☐Hepatitis C	☐Osteoarthritis	☐Tuberculosis
☐COPD	☐HIV	☐Osteoporosis	☐Other _____
☐Coronary Artery Disease	☐Hyperlipidemia	☐Peptic Ulcer Disease	☐Other _____

☐Cancer Type of Cancer _____

REVIEW OF SYSTEMS (Please check if you have had any of the following in the last 6 months) ☐None

☐Fevers	☐Visual loss	☐Abdominal pain
☐Fatigue	☐Double vision	☐Urinary Frequency
☐Weight loss	☐Ringing in ears	☐Urinary incontinence
☐Rash	☐Hearing loss	☐Urinary retention
☐Hives	☐Trouble swallowing	☐Muscle weakness
☐Cancer	☐Chest pain	☐Joint pain
☐Bruising	☐Heart palpitations	☐Joint swelling
☐Easy bleeding	☐Leg swelling	☐Dizziness
☐Swollen glands	☐Coughing	☐Seizures
☐Tremors	☐Sleep apnea	☐Headaches
☐Hair loss	☐Short of breath	☐Depression
☐Excessive thirst	☐Nausea	☐Anxiety
☐Blurry vision	☐Vomiting	☐Insomnia

☐Other _____

FAMILY HISTORY	Alive	Age	Medical Problems	Deceased	Cause of Death
Paternal Grandfather	☐	___	_____	☐	_____
Paternal Grandmother	☐	___	_____	☐	_____
Maternal Grandfather	☐	___	_____	☐	_____
Maternal Grandmother	☐	___	_____	☐	_____
Father	☐	___	_____	☐	_____
Mother	☐	___	_____	☐	_____
Sister/Brother	☐	___	_____	☐	_____
Sister/Brother	☐	___	_____	☐	_____
Sister/Brother	☐	___	_____	☐	_____

This information is true and complete to the best of my knowledge.

_____ ____/____/_____

Signature of Patient or Legal Guardian Date