

VCU Medical Center

Virginia Commonwealth University

Neurosurgery Patient Questionnaire

Date: _____ Patient Name: _____

Date of Birth: _____ Height _____ Weight _____

Address: _____

Phone: (H) _____ (W) _____ (C) _____

E-mail Address: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Referring Physician: _____

Address: _____

Phone #: _____ Fax #: _____

Primary Care Physician: _____

Address: _____

Phone #: _____ Fax #: _____

Insurance co: _____ **Policy/group #** _____

Present History

What is the main reason for your visit today?: _____

When and how did your problem start? _____

Describe the location of your symptoms and/or pain _____

Describe your symptoms: burning numb stabbing pins ache tingling weakness
other: _____

Please indicate the severity of your pain on a scale from 1 to 10 ("10" being most severe, "0" if no pain)?

At Worst

0 1 2 3 4 5 6 7 8 9 10

No pain worst pain imaginable

At Best

0 1 2 3 4 5 6 7 8 9 10

No pain worst pain imaginable

Now

PATIENT NAME _____

1

Date of Birth _____

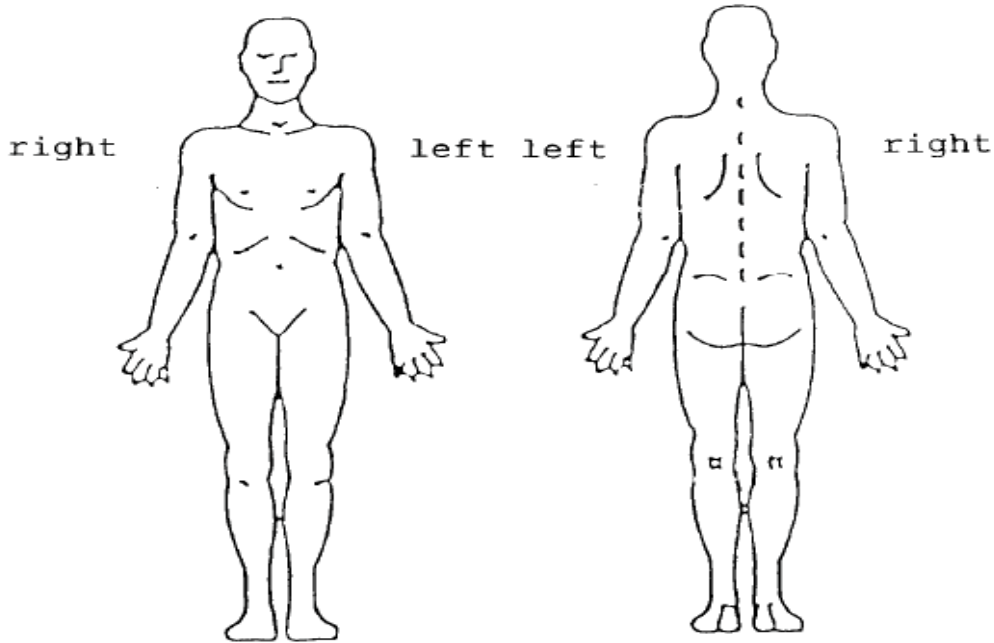
OVER →

0 1 2 3 4 5 6 7 8 9 10
No pain worst pain imaginable

What makes your symptoms/pain worse? _____

What helps to relieve your symptoms (e.g. ice, heat, sitting, standing)? _____

IF APPLICABLE: Please mark the areas where you have pain, numbness, or other symptoms



Have you had any of the following treatments?

___ Physical therapy ... duration _____ Traction...duration _____

___ Pain medications.... name/duration _____

___ Anti-inflammatories.... name/duration _____

___ Muscle relaxants...name/duration _____

___ Injections...please list _____

___ Other...please list _____

Please list any X-rays, CT Scans, MRIs, nerve studies, or any other tests related to your condition that you have had: _____

Past Medical History

(Please check all that apply to you or your family, now or in the past)

Patient	Family		Patient	Family	
_____	_____	High blood pressure	_____	_____	Stomach ulcers / upset
_____	_____	Diabetes	_____	_____	Thyroid problems
_____	_____	Heart disease	_____	_____	Cancer_____
_____	_____	Anemia	_____	_____	Arthritis
_____	_____	Bleeding problems	_____	_____	Glaucoma
_____	_____	Hepatitis	_____	_____	Seizures
_____	_____	Kidney disease	_____	_____	Stroke
_____	_____	TB (tuberculosis)	_____	_____	Migraines
_____	_____	Asthma	_____	_____	Depression/anxiety
_____	_____	Incontinence	_____	_____	Problems with surgery_____
_____	_____	Chronic bronchitis	_____	_____	HIV positive
_____	_____	Sleep Apnea	_____	_____	Other_____

Past Surgical History

Please List All Surgeries

Date	Surgery	Doctor / Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Work Status: Employed Unemployed Retired

Occupation: _____

Are you currently able to work? YES NO

If not working, is it due to this problem? YES NO When did you last work? _____

Was your current condition caused by?

Work related injury Date: _____ Is this a workers compensation case? YES NO

Motor vehicle accident Date _____ Is this a personal injury case? YES NO

Are you on Disability? YES NO..... In the process of obtaining Disability? YES NO

Do you use tobacco?(check all that apply) NO YES.....

Cigarettes Cigars Chew Amount _____

Do you consume alcoholic beverages? (check all that apply) NO YES.....

Beer Wine Liquor Amount _____

Have you ever been told you have a drinking problem? YES NO

Do you now or have you ever abused prescription drugs or other illegal drugs? YES NO

Please describe _____

Do you drink coffee or drinks with caffeine? YES NO. If so how many per day? _____

Review of Systems

Have you ever had any of the following (Please check any that apply):

General: Any UNEXPLAINED.... weight loss/gain weakness night sweats fevers chills
 loss of appetite none

Skin: Rashes Easy bruising other sores yellow skin (jaundice) none

Head: Injury Dizziness Headaches other _____ none

Eyes: Vision changes cataracts glaucoma none

Ears: ringing pain drainage other _____ none

Nose: changes in sense of smell sinusitis other _____ none

Throat: Sores on gums lumps trouble swallowing other _____ none

Lungs: shortness of breath bronchitis pneumonia sleep apnea
 chronic cough blood clot in lung TB (tuberculosis) none

Heart: chest pain heart attack blocked arteries swelling murmurs
 irregular heart beat trouble breathing while laying none

GI: acid reflux ulcer stomach pain bloody or dark stools constipation
 diarrhea nausea vomiting changes in bowel habits hepatitis none

GU: Change in bladder habits bloody or dark urine trouble voiding
 unable to hold urine sexual dysfunction kidney stones none

Endocrine: diabetes thyroid condition none

Musculoskeletal: broken bones arthritis joint pain none

Vascular: leg pain with walking blood clots none

Hematology: free bleeding anemia sickle cell trait none

Neurological: seizures stroke migraines none

Psychological: depression anxiety other _____ none

Miscellaneous: allergy to eggs problems with surgery none

Other: _____

Reviewed and confirmed, 4 pages (MD Signature)