NEUROSURGICAL ASSESSMENT QUESTIONNAIRE

PATIENT'S NAME: ______________________ DATE: ____________

DOCKET #: ________

REFERRING PHYSICIAN: ______________________

Purpose of the appointment ? ______________________

Date of first appearance of symptoms: ______________________

Please describe signs and symptoms: ______________________

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Please mention treatment received for this problem: ______________________

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Present Medical History:

Current Illness:		Medications prescribed
HYPERTENSION		
DIABETES		
HIGH CHOLESTEROL		
OTHER (PLEASE SPECIFY)		

Family History: / Past Medical History:

Condition	YES	NO	Please Specify:	Surgeries/ Hospital	Complications
Heart Disease					
Cancers					
Diabetes					
Hypertension					
Thyroid Problems					
Psychiatric Illness					

Social History:

Are you Right handed ☐ Left handed ☐

Occupation: ____________ Do you have children? Yes ☐ No ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Do you smoke: No ☐ Yes ☐ ____ packs per day for ______ years

Do you drink alcohol: No ☐ Yes ☐ Please estimate amount: ______

Do you live alone: No ☐ Yes ☐

Allergies:______________________ Reaction:______________________