Washington Township Medical Foundation

Part of Washington Hospital Healthcare System

Neurosurgery Department

Patient Name:_____

Date:_____

Constitutional:	Yes	No	Explain if you feel necessary
Fevers			
Chills			
Drenching night sweats			
Unintended weight changes of greater than 10 pounds			

Urinary:	Yes	No	Explain if you feel necessary
Complete loss of control of being able to urinate			
Mild urinary hesitancy			
Mild urinary leakage			
Other			

Gastrointestinal/Stomach:	Yes	No	Explain if you feel necessary
Constipation			
Bloody stool			
Dark/tarry stool			
Diarrhea			
Other			

Neurological:	Yes	No	Explain if you feel necessary
Loss of sensation in genitalia			
Problems with balance			
Numbness or tingling in arms or legs			
Other			

Blood/cancer	Yes	No	Explain if you feel necessary
Any known types of cancer at any point in your life?			
Clotting disorder			
Abnormal/easy bleeding			
History of blood transfusion			
Other			

DO YOU HAVE ANY IMAGES? YES / NO

IF SO, PLEASE GIVE THESE TO THE FRONT DESK TO BRING UP THE IMAGES ON THE COMPUTER. THIS WILL MAKE IT MORE LIKELY FOR DR. GOLDIN TO REVIEW THE IMAGES DIRECTLY WITH YOU

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PLACE PATIENT LABEL HERE

Pt Name: _____

CURRENT MEDICATION

(Please include all over-the-counter medications, herbal medications, and vitamins

Medication Name	Dosage	Route (oral, patch, injection, etc.)	Frequency (per day, week, or as needed

ALLERGIC REACTIONS

Are you allergic to any medications? If so, list the medication and the reaction you had.

Medication Name	Reaction (circle all that apply)
Example: Aspirin	Anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:
	Anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:
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	Anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:

List all other drug/medication allergies and their reaction:

Other allergies

Have you had a reaction to any of the following?

YES NO Latex

YES NO Iodine

YES NO Intravenous contrast agent (used in CT scans)

List any other allergies:

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Pt Name: _____

MEDICAL HISTORY: Please mark yes or no to any of these medical conditions for which you have been diagnosed:

Condition	YES	NO
Arrhythmia		
Angina		
Asthma		
Allergies		
Atrial fibrillation		
Autoimmune disease		
Bleeding disorder		
Cancer		
Chest pain		
Chronic bronchitis		
COPD (chronic obstructive pulmonary disease)		
Cirrhosis		
Clotting disorder		
CHF (congestive heart failure)		
Depression		
Diabetes		
Easy bruising		
Emphysema		
GERD (gastro-esophageal disease)		
Headaches		
Heart disease		
Heart murmer		

Condition	YES	NO
Heart valve problems		
Hepatitis - chronic		
HIV / AIDS		
Hypertension		
Kidney disease		
Liver disease		
Lung disease		
Melanoma		
Meningitis		
Myocardial infarction		
Nerve/muscle disease		
Other neurological disorders		
Palpitations		
Psychiatric treatment		
Pulmonary embolus		
Renal insufficiency		
Seizures		
Sickle cell anemia		
Sinus disorder		
Stroke		
Substance abuse		
Thyroid disease		
Ulcers		

SURGICAL HISTORY: Please mark "yes" for any of the below surgeries you have had and list approximate date of surgery:

Condition	YES	DATE
Appendectomy		
Brain surgery		
Breast surgery		
Cholecystectomy (removal of gallbladder)		
Colon surgery		
Coronary artery bypass surgery		
Gallbladder surgery		
Heart surgery		

Condition	YES	DATE
Hernia repair		
Hysterectomy		
Joint replacement		
Liver surgery		
Pancreas surgery		
Prostate surgery		
Spine surgery		
Thyroid surgery		

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Pt Name: _____

FAMILY HISTORY:

Please check the box for any of the family members that have had these medical concerns:

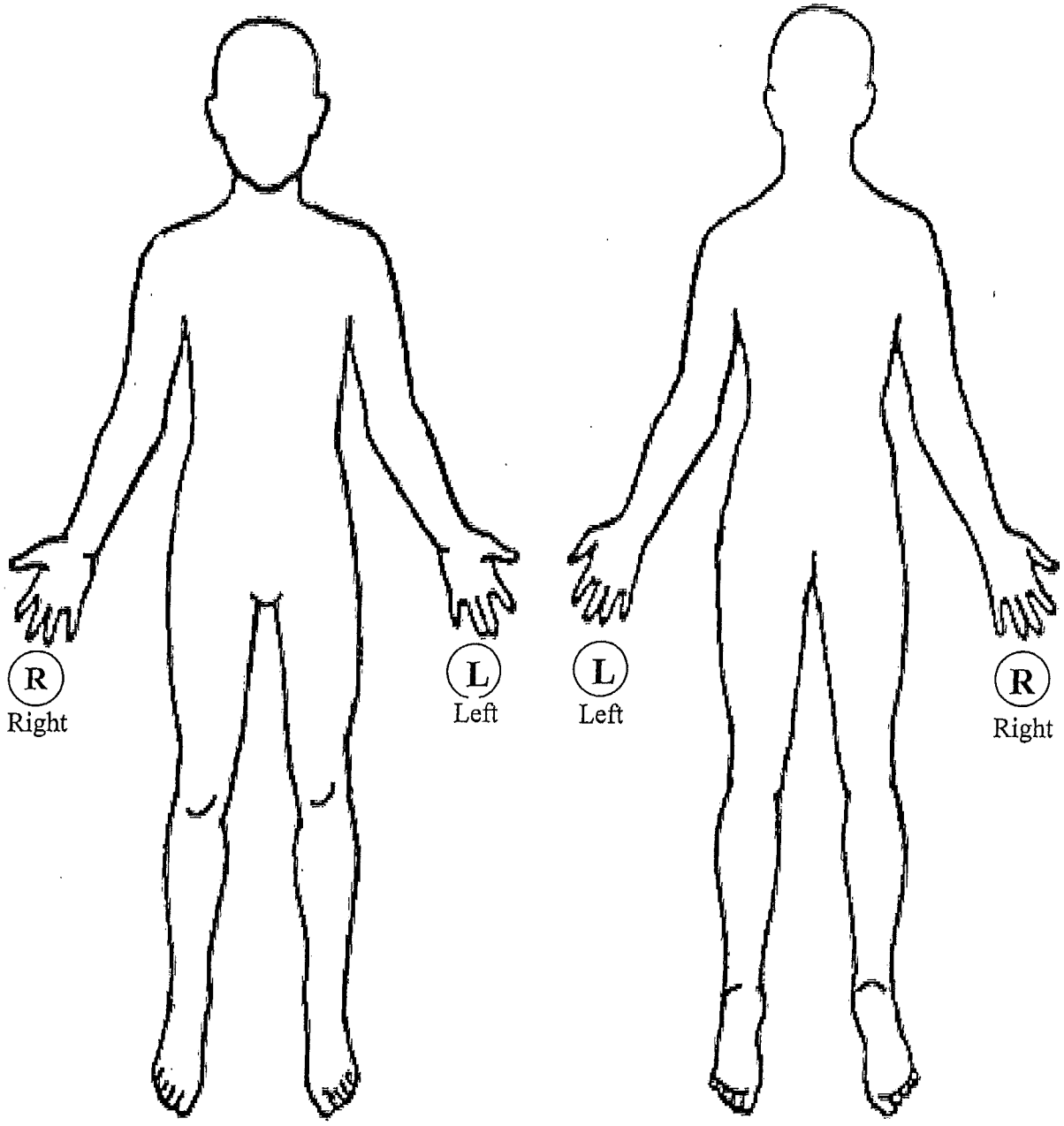
Family Member	Anesthesia Problems	Brain Cancer	Cancer	Clotting Disorder	High Blood Pressure	Stroke	Cardiac Stent	Heart Disease
Mother								
Father								
Sister								
Brother								
Daughter								
Son								

SOCIAL HISTORY:

Education	Less than grade school Grade school Middle school High school College graduate
Marital Status	Single Married Widowed Divorced Legally Separated
Do you live alone?	No Yes
Currently employed?	No Yes If yes, what is your occupation?
Do you smoke cigarettes?	No Yes If yes, how many packs/day? How long?
Did you previously smoke cigarettes?	No Yes If yes, how many packs/day? When did you quit?
Do you drink alcoholic beverages?	No Yes If yes, how many drinks/day? What kind?
Do you use any of the following drugs?	cocaine crack LSD marijuana heroin other/recreational: _____
Have you used prescription medications more often than prescribed, or for a reason other than as prescribed?	No Yes
Is your visit today in relation to a lawsuit?	No Yes
Is this visit today in relation to a worker's comp claim?	No Yes

Use the following to indicate the location of where you are experiencing sensations in/on your body:

000 (Numbness) XXX (Aching) //// (Stabbing or Burning) +++ (Pins and Needles)



Please indicate your level of pain: 1 2 3 4 5 6 7 8 9 10

Provider to complete:

☐ Needs nutritional screen ☐ Patient education provided: _____

☐ Readiness to learn assessed ☐ Social work referral made _____

Vital Signs: BP_____ HR_____ Temp_____ RR_____ HT_____ WT_____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____