Washington Township Medical Foundation
Part of Washington Hospital Healthcare System

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CEREBROVASCULAR, INTERVENTIONAL AND GENERAL NEUROSURGERY

PLEASE COMPLETE ALL SECTIONS OF THIS FORM

Patient Name:_____ Date of Birth:_____

Referring Doctor ? (Name, telephone number and address)_____

_____

_____

Chief Complaint: Why have you come here?_____

How did it start?_____

What are the symptoms?_____

How long have you had symptoms?_____

Have the symptoms improved or worsened recently?_____

Medications (Specify type and schedule):_____

_____

_____

Allergies to medication: (specify what allergic reaction you have, e.g., rash, wheezing)

_____

_____

_____

Past medical and surgical history: (include dates if possible)

Hospitalizations:_____

_____

Surgery:_____

_____

Major medical illnesses:_____

_____

Family History: Check any of the following that apply to your family.

- ❑ heart
- ❑ diabetes
- ❑ cholesterol
- ❑ cancer
- ❑ vascular
  - ☐ Stroke
  - ☐ Arterial Disease
  - ☐ Aneurysms
- ❑ autoimmune diseases
- ❑ neck & back problems

SPECIFY FAMILY MEMBER(S) IF POSSIBLE:_____

_____

_____

What have people in your family died from?_____

_____

Social History

Marital Status:_____

Occupation: _____

Alcohol and tobacco consumption (type and frequency, duration in years):_____

_____

_____

Review of Systems: CHECK any of the following that apply to you.

General / constitutional:

- ❑ appetite
- ❑ digestion
- ❑ energy level
- ❑ sleep habits and adequacy
- ❑ weight loss or gain (specify amount and duration):_____

_____

HEENT:

Head: ❑ swelling ❑ sinusitis ❑ infection ❑ closed head injury

Eyes: ❑ eye pain ❑ eye infection ❑ visual Loss ❑ photosensitivity
❑ inflammation / bleeding ❑ visual disturbance ❑ color vision problem

Ears: ❑ discharge ❑ muffled hearing ❑ hearing loss ❑ ear pain/ fullness

Nose: ❑ pain ❑ bleeding ❑ discharge ❑ deviated septum ❑ airway obstruction

Throat: ❑ pain ❑ swelling ❑ discharge ❑ sputum ❑ tonsillitis

Review of Systems (cont'd)**: CHECK** any of the following that apply to you.

Respiratory:

- ❑ asthma
- ❑ wheezing
- ❑ shortness of breath
- ❑ painful breathing
- ❑ bronchitis
- ❑ pneumonia
- ❑ cough
- ❑ sputum
- ❑ bloody secretion
- ❑ lung collapse
- ❑ emphysema
- ❑ pleuritis
- ❑ cigarette smoking history
- ❑ upright sleeping

Cardiovascular:

- ❑ heart attack
- ❑ angina
- ❑ high blood pressure
- ❑ coronary artery disease
- ❑ heart valve disease
- ❑ history of rheumatic fever
- ❑ congestive heart failure
- ❑ cardiomyopathy
- ❑ heart rhythm disturbance
  - ☐ atrial fibrillation
  - ☐ WPW
- ❑ blood lipid abnormalities
  - ☐ high cholesterol
  - ☐ triglycerides
- ❑ diabetes
- ❑ congenital heart defect

Gastrointestinal:

- ❑ swallowing difficulties
- ❑ change in bowel habits
- ❑ bright red blood in stool
- ❑ tarry stool
- ❑ incontinence of stool
- ❑ anorexia
- ❑ nausea
- ❑ vomiting
- ❑ diarrhea
- ❑ constipation
- ❑ gastroesophageal reflux disease
- ❑ peptic ulcer
- ❑ gallbladder disease
- ❑ gallstones
- ❑ gastritis
- ❑ stomach sensitivity to medication such as aspirin
- ❑ enterocolitis
- ❑ dysentery
- ❑ history of parasitic disease (tapeworm)
- ❑ pancreatitis
- ❑ vitamin deficiency
- ❑ lactose intolerance
- ❑ fat intolerance
- ❑ cancer or other neoplasm of GI tract
- ❑ other digestive problems: _____

Genitourinary:

- ❑ painful urine
- ❑ blood in urine
- ❑ frequency or urgency of urine
- ❑ kidney stone
- ❑ kidney anomaly
  - ☐ solitary kidney
  - ☐ polycystic kidney disease
- ❑ prostate cancer
- ❑ prostatic hypertrophy
- ❑ erectile dysfunction
- ❑ history of sexually transmitted disease
- ❑ ovarian cyst
- ❑ ovarian tumor
- ❑ uterine bleeding
- ❑ uterine fibroids
- ❑ uterine cancer
- ❑ testicular cancer

Review of Systems (cont'd)**: CHECK** any of the following that apply to you.

Hematological (disorders of the blood):

- ❑ anemia
- ❑ thalassemia
- ❑ platelet dysfunction
- ❑ bleeding tendency
- ❑ clotting tendency
- ❑ blood factor anomaly (e.g., Factor V Leiden, Protein C or Protein S abnormality)
- ❑ blood lipid disorder
- ❑ white blood cell disorder
- ❑ red blood cell disorder
- ❑ history of blood cancer
  - ☐ leukemia
  - ☐ lymphoma
- ❑ autoimmune disorder (e.g., lupus erythematosus)

Endocrine (hormonal):

- ❑ thyroid disease
- ❑ pituitary disorder or tumor
- ❑ adrenal disorder (Addison's disease)
- ❑ diabetes

Skin:

- ❑ rash (e.g., eczema)
- ❑ skin cancer
  - ☐ melanoma
  - ☐ basal cell type
  - ☐ squamous cell type
- ❑ healing abnormalities
  - ☐ wound healing problems
  - ☐ keloid formation
  - ☐ scar discoloration

Neuromuscular:

- ❑ headache
- ❑ previous stroke or TIA
- ❑ seizure
- ❑ fleeting blindness
- ❑ other visual disturbance
  - ☐ double vision
  - ☐ blurred vision
- ❑ memory disturbance
- ❑ weakness of one side of body
- ❑ coordination difficulty or clumsiness
- ❑ difficulty with balance
- ❑ walking dysfunction
  - ☐ rhythm
  - ☐ balance
  - ☐ pain
- ❑ loss of muscle mass (specify): _____
- ❑ painful face
- ❑ movements of the face or eyes
- ❑ lancinating pain (e.g., sciatica)
- ❑ sensory dysfunction
  - ☐ numbness
  - ☐ tingling
  - ☐ electrical sensation
- ❑ speech dysfunction
  - ☐ (inability to speak smoothly
  - ☐ word finding difficulty
  - ☐ difficulty understanding speech)
- ❑ problems with special senses
  - ☐ hearing
  - ☐ vision
  - ☐ smell
  - ☐ taste: specify_____

Skeletal/rheumatic:

- ❑ connective tissue disorder (e.g., Marfan's syndrome, collagen deficiency)
- ❑ fracture
- ❑ osteopenia or osteoporosis
- ❑ arthritis (specify):_____

Review of Systems (cont'd)**: CHECK** any of the following that apply to you.

Infectious Diseases:

- ❑ chronic infection
- ❑ current infection
- ❑ use of antibiotics
- ❑ TB (tuberculosis)
- ❑ exposure to TB
- ❑ immune disorder
- ❑ parasitic illness (e.g., malaria)
- ❑ recent exotic travel (specify): _____
- ❑ history of hepatitis (specify): _____
- ❑ HIV status
- ❑ history of sexually transmitted disease
- ❑ history of blood transfusion

Psychiatric:

- ❑ psychiatric illness or hospitalization
- ❑ anxiety disorder
- ❑ panic disorder
- ❑ depression
- ❑ hallucination
- ❑ compulsive disorder
- ❑ psychiatric medication
- ❑ history of substance abuse
  - ☐ alcohol
  - ☐ medication
  - ☐ illicit drug use

_____ _____

Patient's or Patient Representative's Signature (Date)

_____

Print Name