Physician:_____
Neurosurgeons of Cape Cod, P.C.508-771-0006 **Date:** _____

Name: _____ **DOB:** _____ **Age:** _____
Print Last First Middle

Male ☐ Female ☐

Do you live alone? Yes ☐ No ☐ Do you have children? Yes ☐ No ☐
Occupation:_____ Employer: _____

Symptoms/Problems (in order of severity) Please list present symptoms, complaints, or problems:
1. _____ Date: _____ How? _____
2. _____ Date: _____ How? _____

Personal History:
Do you smoke? Yes ☐ No ☐ How much? _____ How long? _____
Do you use alcohol? Yes ☐ No ☐
Are you pregnant? Yes ☐ No ☐ Is it possible that you could be pregnant? _____

Height: _____ Weight: _____ One year ago? _____ Max. weight? _____ When? _____

Hand preference? Right ☐ Left ☐

Past Medical History:
Illnesses you have had:

Frequent or severe headaches	Yes	☐	No ☐	Polio	Yes	☐	No
High blood pressure	Yes	☐	No ☐	Meningitis	Yes	☐	No
Diabetes	Yes	☐	No ☐	Gonorrhea or Syphillis	Yes	☐	No
Heart trouble	Yes	☐	No ☐	Anemia	Yes	☐	No
Cancer	Yes	☐	No ☐	Phlebitis	Yes	☐	No
Rheumatic heart disease	Yes	☐	No ☐	Migraine headaches	Yes	☐	No
Arthritis (rheumatism)	Yes	☐	No ☐	Epilepsy	Yes	☐	No

Other illnesses requiring hospitalization (include dates):
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Operations (list surgeon and approx. date):
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List Medications you are currently taking (including dosage):
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Medication Allergies: Yes ☐ No ☐
If yes, please list:
1. _____
2. _____
3. _____
4. _____

Are you allergic to Adhesive Tape? _____

Pharmacy Name: Phone:

Have you experienced any of the following in the past year?

Frequent or severe headache	____Yes	____ No	Night sweats	____ Yes	____ No
Fainting or unconscious spells	____Yes	____ No	Chronic or frequent cough	____Yes	____ No
Convulsions (seizures)	____ Yes	____ No	Shortness of breath	____Yes	____ No
Dizziness on change of position	____ Yes	____ No	Palpitations or fluttering heart	____Yes	____ No
Blurred vision	____ Yes	____ No	Swelling of hands, feet, ankles	____ Yes	____ No
Double vision	____ Yes	____ No	Change in appetite	____Yes	____ No
Any change in vision	____ Yes	____ No	Number of pillows slept on	____Yes	____ No
Ringing in your ears	____ Yes	____ No	Nausea or vomiting	____Yes	____ No
Sinus trouble	____ Yes	____ No	Vomited blood	____Yes	____ No
Strange persistent odors	____ Yes	____ No	Abdominal pain	____Yes	____ No
Difficulty swallowing	____ Yes	____ No	Any blood in bowel movement	____Yes	____ No
Chest pain	____ Yes	____ No	Rectal pain with bowel movement	____Yes	____ No
Angina Pectoris	____ Yes	____ No	Pain on urinating	____Yes	____ No
Bloody cough	____ Yes	____ No	Diffiiculty starting urination	____Yes	____ No
Getting up at night to urinate	____ Yes	____ No	Joint pain	____ Yes	____ No
How many times	_____		Swelling of the joints	____ Yes	____ No
Fatigue without apparent reason	____Yes	____No	Brittleness of nails	____ Yes	____ No
Dryness of the skin	____ Yes	____ No	Easy bruising	____Yes	____ No
Inability to stand heat	____ Yes	____ No	Inability to stand cold	____ Yes	____ No
Change in hair texture	____ Yes	____ No	Change in skin texture	____ Yes	____ No
Skin rash	____ Yes	____ No	Menstrual irregularity	____ Yes	____ No

Immediate family history

Do you live with your spouse? ☐ Yes ☐ No

Children	Ages	Health	Problem
_____	_____	☐ Good	_____
_____	_____	☐ Good	_____
_____	_____	☐ Good	_____
_____	_____	☐ Good	_____
_____	_____	☐ Good	_____
_____	_____	☐ Good	_____

Do Any blood relatives have the following major health problems? Who?

☐ AIDS _____	☐ Diabetes _____	☐ Migraine headaches _____
☐ Aneurysm of brain _____	☐ Epilepsy _____	☐ Neurofibromatosis _____
☐ Asthma _____	☐ Heart attack _____	☐ Polycystic kidney _____
☐ Bladder disease _____	☐ Heart problem _____	☐ Psychologic disorder _____
☐ Blood vessel Disease _____	☐ High blood pressure _____	☐ Spina bifida _____
☐ Cancer _____	☐ Lung disease _____	☐ Stroke _____
Type: _____	Type: _____	☐ Other _____

Are there any hereditary diseases in your family that you are aware of? ☐ Yes ☐ No If yes, please list:

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my physician or any member of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ **Patient's Signature**: _____

Physician's Signature: _____