AdventHealth Medical Group

NEUROSURGERY HEALTH QUESTIONNAIRE

Patient Name ______________________ Patient Date of Birth ______________ Age ________ Today's Date ________________

Name of Referring Doctor ______________________ Name of Primary Care Provider ______________________

Patient Email Address ______________________ Preferred Pharmacy ______________________

Preferred Lab ______________________ Preferred Imaging Center ______________________

CHIEF COMPLAINT(S) AND DATE SYMPTOMS STARTED____

____

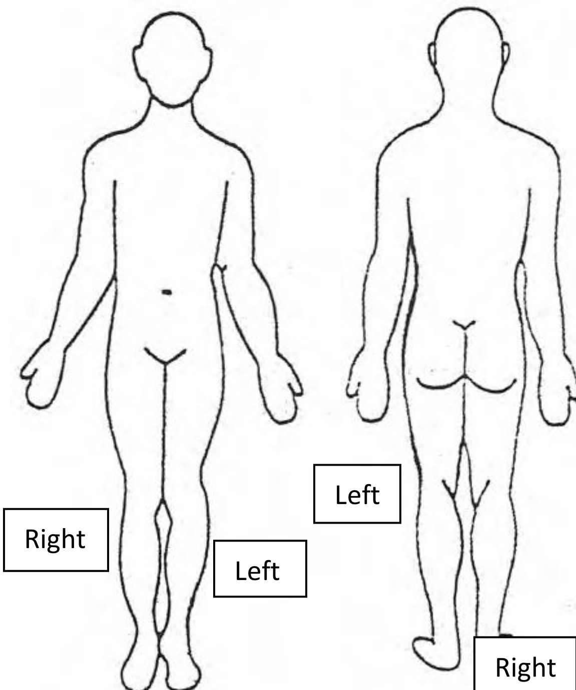
IF INJURY, HOW DID INJURY OCCUR?____

HEIGHT______________________ WEIGHT____________________

TREATMENT FOR CURRENT SYMPTOMS	DATE	TREATMENT FOR CURRENT SYMPTOMS	DATE
☐ Epidural Injections	________________	☐ Chiropractic	________________
☐ Facet Blocks	________________	☐ Bracing	________________
☐ Physical Therapy	________________	☐ Other	________________

LIST ANY PAST SURGERIES	DATE	LIST CURRENT MEDICATIONS / DOSAGES	TIMES PER DAY
_________________________	________________	_________________________	____________
_________________________	________________	_________________________	____________
_________________________	________________	_________________________	____________

ON THE DIAGRAM, SHADE THE AREA WHERE YOU FEEL PAIN. PUT AN X IN THE AREA THAT HURTS THE MOST.



DO YOU SMOKE? ☐ Yes, Amount___________ ☐ No

FORMER SMOKER? ☐ Yes ☐ No HOW LONG DID YOU SMOKE? _______________

DO YOU CONSUME ALCOHOL? ☐ Yes ☐ No AMOUNT_______________

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐ Yes ☐ No

LIST ANY OTHER MEDICAL PROBLEMS

____

____

LIST ANY ALLERGIES

____

____

Do you have religious beliefs that influence your medical decisions? ☐ Yes ☐ No

1. Do you have someone who loves and cares for you? ☐ Yes ☐ No ☐ Not Sure
2. Do you have a source of joy in your life? ☐ Yes ☐ No ☐ Not Sure
3. Do you have a sense of peace today? ☐ Yes ☐ No ☐ Not Sure

If you answered "No" to any questions 1-3, would you like to be contacted by a team member of our Spiritual Wellness team? ☐ Yes ☐ No

NEUROSURGERY HEALTH QUESTIONNAIRE

CHECK ANY PAST ILLNESSES

- ☐ Cancer
- ☐ Rheumatic Fever
- ☐ Epilepsy
- ☐ Asthma
- ☐ Kidney Problems
- ☐ Pancreatitis
- ☐ Hypertension
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Clotting Problems
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Liver Problems
- ☐ Bronchitis
- ☐ Drug Problem

FAMILY HEALTH HISTORY

MOTHER

- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke

FATHER

- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke

GRANDMOTHER (Please indicate Maternal or Paternal)

- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke

GRANDFATHER (Please indicate Maternal or Paternal)

- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke

SISTER

- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke

BROTHER

- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke