

NEUROSURGERY ARKANSAS
9601 LILE DRIVE, SUITE 310
LITTLE ROCK, ARKANSAS 72205

IS THE PROBLEM FOR WHICH YOU ARE BEING SEEN THE RESULT OF:
WORK RELATED INJURY _____ AUTO ACCIDENT _____ OTHER ACCIDENT _____
GIVE DATE AND BRIEF DESCRIPTION _____

PATIENT _____
LAST NAME _____ FIRST _____ MIDDLE _____

ADDRESS _____
STREET _____ CITY _____ STATE _____ ZIP _____

TELEPHONE: HOME (____) _____ WORK (____) _____ CELL/PAGER _____

AGE: _____ BIRTHDATE: _____ SSN: _____ SEX: MALE _____ FEMALE _____

SINGLE _____ MARRIED _____ WIDOWED _____ DIVORCED _____

PATIENT'S EMPLOYER _____
NAME _____ ADDRESS _____

SPOUSE'S NAME _____
SSN _____

EMERGENCY CONTACT PERSON _____
RELATIONSHIP _____

ADDRESS _____
PHONE _____

FAMILY PHYSICIAN _____
NAME _____ ADDRESS _____

REFERRING PHYSICIAN _____
NAME _____ ADDRESS _____

HAVE YOU EVER SEEN ANY DOCTOR IN THIS GROUP? _____

IF MINOR, PARENTS OR GUARDIANS _____
NAME & ADDRESS _____ RELATIONSHIP _____

PHONE: HOME _____ WORK _____ DOB _____ SSN _____

EMPLOYER _____
NAME _____ ADDRESS _____

I HEREBY AUTHORIZE NEUROSURGERY ARKANSAS TO RELEASE ANY INFORMATION ACQUIRED
IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MY PRIMARY AND/OR REFERRING
PHYSICIANS AND MY LISTED INSURANCE COMPANIES. ADDITIONAL PARTIES WILL BE SUPPLIED
REPORTS IF REQUESTED BELOW.

PATIENT OR GUARDIAN'S SIGNATURE _____ DATE _____

NAME OF ADDITIONAL REQUESTED PARTIES (ATTORNEY, EMPLOYER, ETC. . .) _____

ADDRESS _____

DOCTOR _____ CHART # _____

NEUROSURGERY ARKANSAS
MEDICAL HISTORY QUESTIONNAIRE

Confidential Record: Information contained here will not be released without your authority.

Name: _____ Date: _____ Age: _____

Problem that you are here to be seen for today: _____

Please tell us about your previous and ongoing illnesses such as (but not limited to):

Heart Disease Lung Problems
Heart Attach Diabetes
High Blood Pressure Kidney Problems

Anemia
Bleeding Problems
Stomach Problems Epilepsy
Stomach Ulcers
Other GI Problems

Illness & Surgery Approx. Date Comments

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list medications you are currently taking:

Medication Dose Comments

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any medications to which you are allergic or which cause you problems:

When Medication Describe Reaction

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Over)

Habits: Yes No How Much?

Tobacco _____

Alcohol _____

OCCUPATIONAL HISTORY:

Current Occupation: _____ For how long? _____

Are you currently working? _____ If not, date last worked _____

FAMILY HISTORY:

Do any illnesses occur frequently in your family?"

Illness _____ Comments _____

SYSTEM REVIEW:

Height _____ Weight _____

Please rate on a scale of 1-10 the degree of pain that you have on an average daily basis.

1 2 3 4 5 6 7 8 9 10

No Pain _____ Strong enough to go to the emergency room _____

Skin Rash _____ Yes No Comment _____
Easy Bruising _____

Head Headache _____

Eye Recent Vision Change _____

Ears Other: _____

Infections _____

Vertigo (Dizziness) _____

Respiratory (Lungs) _____

Shortness of Breath _____

Unusual Cough _____

Asthma _____

Heart Chest Pain (Angina) _____

Palpitations or Fluttering _____

Gastrointestinal (Stomach) _____

Difficulty Swallowing _____

Indigestion or Abdominal pain _____

Change in Bowel Habits _____

Genitourinary (Kidneys & Bladder) _____

Difficulty Controlling Urination _____

Kidney or Bladder Infection _____

Musculoskeletal (Bone, Muscles _____

Painful or Swollen joints _____

Muscle or Extremity Weakness _____

Psychiatric _____

Anxiety (nervousness) _____

Depression _____

Women _____

Menstrual Abnormalities _____