

**Comprehensive Patient History Form**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

**Past Medical History:** *(check all that apply)*

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Acid Reflux             | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Heart disease           | <input type="checkbox"/> Migraines                       |
| <input type="checkbox"/> Alcohol or Drug Problem | <input type="checkbox"/> Colitis/Crohns      | <input type="checkbox"/> Heart valve problems    | <input type="checkbox"/> Mental Health Diagnosis         |
| <input type="checkbox"/> Allergy problems        | <input type="checkbox"/> Chronic pain        | <input type="checkbox"/> Hernia                  | <input type="checkbox"/> MRSA                            |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Depression, Anxiety | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Osteoporosis                    |
| <input type="checkbox"/> Artery/Vein problems    | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High cholesterol        | <input type="checkbox"/> Recurrent skin infections       |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Esophagitis, ulcers | <input type="checkbox"/> HIV                     | <input type="checkbox"/> Recurrent UTI                   |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Irritable bowel         | <input type="checkbox"/> Seizures                        |
| <input type="checkbox"/> Autoimmune disease      | <input type="checkbox"/> Gallstones          | <input type="checkbox"/> Kidney disease          | <input type="checkbox"/> Sexually transmitted Infections |
| <input type="checkbox"/> Bleeding problems       | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Kidney stones           | <input type="checkbox"/> Sleep Apnea                     |
| <input type="checkbox"/> Blood clots             | <input type="checkbox"/> Gout                | <input type="checkbox"/> Liver disease/Hepatitis | <input type="checkbox"/> Stroke                          |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Lung disease            | <input type="checkbox"/> TB                              |
|  |  |  | <input type="checkbox"/> Thyroid diseases                |

Other diseases not listed above: \_\_\_\_\_

Hospitalizations/Significant injuries: \_\_\_\_\_

**Surgery/Procedures History:** *(check all that apply)*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Appendix             | <input type="checkbox"/> Heart Surgery                             | <input type="checkbox"/> Joint replacement/Orthopedic surgery |
| <input type="checkbox"/> Bladder Suspension   | <input type="checkbox"/> Bypass                                    | <input type="checkbox"/> Kidney surgery                       |
| <input type="checkbox"/> Blood vessel surgery | <input type="checkbox"/> Heart valve surgery                       | <input type="checkbox"/> Organ Transplant                     |
| <input type="checkbox"/> Arteries             | <input type="checkbox"/> Angioplasty (balloon)                     | <input type="checkbox"/> Prostate surgery                     |
| <input type="checkbox"/> Veins                | <input type="checkbox"/> Stents                                    | <input type="checkbox"/> Thyroidectomy                        |
| <input type="checkbox"/> Colon/Rectal surgery | <input type="checkbox"/> Pacemaker                                 | <input type="checkbox"/> Sinus surgery                        |
| <input type="checkbox"/> Dental surgery       | <input type="checkbox"/> Hysterectomy                              | <input type="checkbox"/> Tonsils and/or adenoids              |
| <input type="checkbox"/> Eye surgery          | <input type="checkbox"/> Complete <input type="checkbox"/> Partial | <input type="checkbox"/> Tubal Ligation                       |
| <input type="checkbox"/> Gallbladder          | <input type="checkbox"/> Hernia                                    | <input type="checkbox"/> Vasectomy                            |

Other surgery not listed above: \_\_\_\_\_

Previous reaction to anesthesia: (explain) \_\_\_\_\_

Please list the names of other practitioners you have or are currently seeing: \_\_\_\_\_



Patient Name \_\_\_\_\_

DOB \_\_\_\_\_

**Medication List:**

Please list **all** prescription and non-prescription medications. This includes vitamins, herbal medicine, supplements, birth control pills, inhalers and over the counter medications.

Medication	Dosage	How often	Disease or Reason	Prescribed by

List all medications you have stopped taking in the last 12 months: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies or reactions:**

Medication/Food/Environmental	Reaction	Medication/Food/Environmental	Reaction
1.		2.	
3.		4.	
5.		6.	

Preferred Pharmacy: \_\_\_\_\_



Patient Name \_\_\_\_\_

DOB \_\_\_\_\_

Name: \_\_\_\_\_

**Family History:**

Family Member	Age(s)	Living	Cause of Death
Father			
Mother			
Brother(s) #			
Sister(s) #			

**Diseases in the family:** (check all that apply)

- |   |                                   |  |   |
|---|-----------------------------------|--|---|
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Depression/Anxiety  | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Addiction problems | <input type="checkbox"/> Breast   | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Kidney disease   |
| <input type="checkbox"/> Bleeding problems  | <input type="checkbox"/> Colon    | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Liver disease    |
|   | <input type="checkbox"/> Prostate | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Mental Illness   |
|   | <input type="checkbox"/> Other    |  |   |

**Social History:**

Do you live: Alone  with Spouse or Partner  with Family  Other

Who do you rely on for support and help? \_\_\_\_\_

Do you smoke?  Currently  Past  Never \_\_\_\_\_ packs/day for \_\_\_\_\_ years Date quit: \_\_\_\_\_

If you do smoke, are you interested in quitting?  YES  NO

Other nicotine use  YES  NO

Exposure to second hand smoke?  YES  NO

Do you drink alcohol?  YES  NO  Beer  Wine  Liquor How many drinks per week? \_\_\_\_\_

How many caffeinated beverages per day? \_\_\_\_\_  Coffee  Tea  Sodas  Energy Supplements

Any recreational drug use?  YES  NO

Type: \_\_\_\_\_

Do you exercise regularly?  YES  NO If so how many times per week? \_\_\_\_\_ Type of exercise: \_\_\_\_\_

Do you feel safe in your home?  YES  NO

How many hours of sleep do you get per night? \_\_\_\_\_ Do you wake feeling well rested?  YES  NO



Patient Name \_\_\_\_\_

DOB \_\_\_\_\_

**Preventative Care:**

Date of last Colon and Rectal Screening: \_\_\_\_\_

Have you had a bone density (DEXA) exam?  YES  NO Date: \_\_\_\_\_

Date of last eye exam: \_\_\_\_\_ Date of last dental exam: \_\_\_\_\_

Immunizations	Date	Immunizations	Date
Tetanus		Hepatitis A	
Influenza/Flu		Hepatitis B	
Pneumonia		Shingles	
Whooping Cough		HPV	

**For our FEMALE patients only:**

Date of last menstrual period: \_\_\_\_\_

Do you have a Gynecologist  YES  NO If yes, Gynecologist name: \_\_\_\_\_

Date of last PAP test: \_\_\_\_\_ Date of last mammogram: \_\_\_\_\_

Have you gone through menopause?  YES  NO

Menstrual problems:  Irregular  Heavy  Change in frequency \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_ Number of live births: \_\_\_\_\_ Current birth control method: \_\_\_\_\_

**For our MALE patients only:** Date of last PSA test: \_\_\_\_\_ Date of last rectal exam: \_\_\_\_\_

**For our Pediatric patients only:** (Please answer from the child's perspective)

What is the current marital status of the child's parents?

Married  Single  Divorced  Separated  Widow  Widower

Who does the child primarily reside with?  Both parents  Mother  Father  Other: \_\_\_\_\_

Does the child have siblings?  Yes  No If yes, # of brothers \_\_\_\_\_ # of sisters \_\_\_\_\_

Does the child attend daycare?  Yes  No If yes, average # of days per week \_\_\_\_\_

If school age, current grade in school \_\_\_\_\_

# Kootenai Clinic Neurosurgery

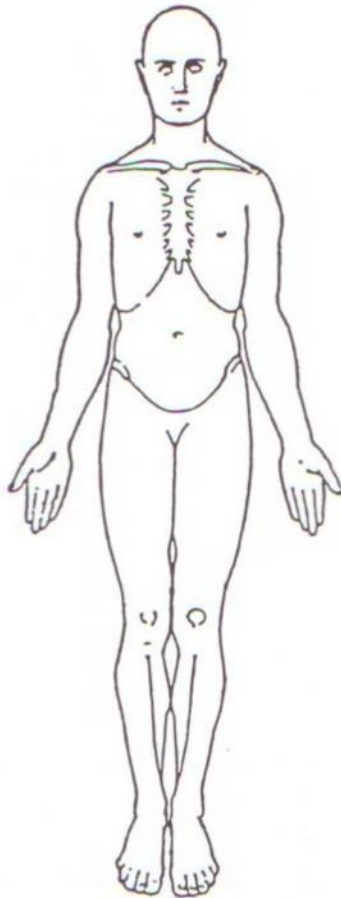
Date \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

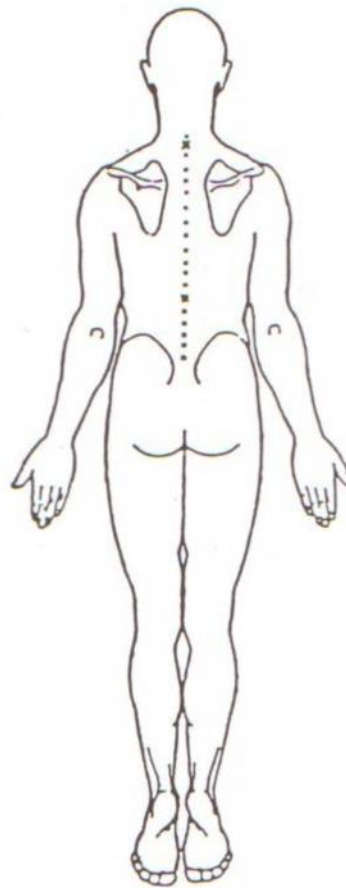
## Sensation Drawing

Mark the area on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Symptom	Ache	Burning	Numbness	Pins & Needles	Stabbing
Symbol	~~~~	XXXX	OOOO	////	====



Front  
Right Left



Back  
Left Right