UCLA Neurosurgical Associates
Patient Health History Form

Patient Name: Age: Date of Birth ☐ Right-Handed ☐ Left-Handed

Name/address/phone of Physician requesting consultation:

Chief complaint/reason for today's visit:

Past History: List any prior major illnesses and/or injuries

Surgeries/Hospitalizations	**Year**	**Complications**

Have you ever had problems with anesthesia? ☐ Yes ☐ No

Current Medication(s) including Aspriin and Dietary Supplements	**Dose**	**Frequency**

Allergies/reactions to medications, anesthetics or materials:

Special Diet

Exercise

Family History

Do you have a family history of trouble with anesthesia? ◯ Yes ◯ No
Do you have a family history of easy bleeding? ◯ Yes ◯ No

	Living and Well	Living, not well	Deceased
Father			
Mother			
Sibilings			
Children			

Social History:
Do you smoke?

- ◯ Yes I've smoked — How many packs per day? [ ] How Many Years [ ]
- ◯ Yes, I smoke cigars or a pipe
- ◯ No, I have never smoked
- ◯ No, I quit — How many years ago? [ ] How many packs per day? [ ] How Many Years [ ]

Do you drink alcohol?

- ◯ Never(rarely)
- ◯ No, but I used to
- ◯ Daily
- ◯ One or more times per week
- ◯ One or more times per month

Review of Systems:
Are you currently, or have you had, problems with :

Constitutional

- ☐ Weight gain
- ☐ Weight loss
- ☐ Night sweats
- ☐ Insomnia

Eyes

- ☐ Double vision
- ☐ Visual loss

Ear, Nose, Throat, and Mouth

- ☐ Hearing loss
- ☐ Noise/ringing in ears
- ☐ Nasal congestion
- ☐ Sore throat
- ☐ Double vision
- ☐ Trouble swallowing
- ☐ Hoarseness

Cardiovascular

- ☐ Chest pain or angina
- ☐ Heart trouble
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ High blood pressure

Neurological

- ☐ Numbness
- ☐ Weakness
- ☐ Stroke
- ☐ Headache

Psychiatric

- ☐ Depression

Allergic/Immunologic

- ☐ Sneezing
- ☐ Itchy eyes/nose
- ☐ Itchy throat
- ☐ Skin rash
- ☐ HIV

Respiratory

- ☐ Asthma
- ☐ Cough up bloodears
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Trouble breathing at night
- ☐ Snoring

Gastrointestinal

- ☐ Indigestion or heartburn
- ☐ Ulcer
- ☐ Hepatitus
- ☐ Jaundice
- ☐ Blood in stool
- ☐ Black, tarry stools

Genitourinary

- ☐ Bladder troublen
- ☐ Prostate disease
- ☐ Kidney disease
- ☐ Abnormal periods

Musculoskeletal

- ☐ Arthitus

Endocrine

- ☐ Diabetes
- ☐ Thyroid disease

Hematologic

- ☐ Bleeding disorder
- ☐ Easy bleeding

The above information is accurate to the best of my knowledge

_____

Patient Signature *Date*

I have reviewed the above information with the patient

Physician Signature *Date*

Physician Signature *Date*

Physician Signature *Date*