NEUROSURGICAL SPECIALISTS OF NORTH FLORIDA

NORTH FLORIDA REGIONAL HEALTHCARE

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Patient's Name: _____

Social Security Number: _____ Date of Birth:_____

Address: _____City_____State_____ Zip _____

Phone Numbers: Home_____Cell_____Work _____

Medical History

Primary Physician's name: _____ Date of last exam: _____

Have you ever been hospitalized? ____ Yes ____ No. If yes, for what? _____

Have you had flu shot this year? ____ Yes ____ No. Have you had your pneumonia vaccine? ____ Yes ____ No

Do you have a living will? ____ Yes ____ No

Preferred Language? ____ English ____ Spanish ____Other: _____

Race? ____ Black/African American ____ White ____ American Indian/Alaskan Native

____ Asian ____ Native Hawaiian/Pacific Islander

Ethnicity? ____ Hispanic/Latino ____ Not Hispanic/Latino

Which conditions are you currently being treated for or have been treated for in the past: (check)

__Heart disease	__Shortness of breath	__Eye disorder/Glaucoma	__Diabetes
__High cholesterol	__Asthma	__ Kidney/Bladder problems	__Seizures
__High blood pressure	__Lung problems/cough	__ Liver problems/Hepatitis	__Stroke
__Low blood pressure	__Sinus problems	__Headaches/Migraines	__Arthritis
__Heartburn (reflux)	__Seasonal allergies	__Neurological problems	__Cancer
__Blood problems	__Tonsillitis	__Depression/Anxiety	__Ulcers/colitis
__Swollen ankles	__Ear problems	__Psychiatric care	__Thyroid problems

Reviewed By _____ Date_____

Describe any current or past medical treatments not listed above:

_____

_____

List your past surgeries:

_____

_____

Social and Preventive History

Do you smoke or chew tobacco? __Yes(currently) __Yes(past) __Never. How many packs per day? ___

Do you drink any alcohol? __Yes(currently) __Yes(past) __Never. How many drinks per week? _____

Do you currently drink coffee and/or tea? __Yes __No. If yes, how many cups per day? _____

Do you exercise daily/weekly? __Yes __No

Do you use seatbelts while driving? __Yes __No. Do you wear a helmet while riding a bike? __Yes __No

Family Medical History:

	Living	Age	List serious illnesses
Mother	__Yes __No	_____	_____
Father	__Yes __No	_____	_____
Children	__Yes __No	_____	_____
	__Yes __No	_____	_____
	__Yes __No	_____	_____
Siblings	__Yes __No	_____	_____
	__Yes __No	_____	_____
	__Yes __No	_____	_____

Which lab company will you be using LabCorp_____Quest_____Other _____

Reviewed By _____ Date_____

Medication List:

Help us care for you better by telling us what prescriptions, over-the-counter medication, and supplements (including ALL aspirin, Ibuprofen, Aleve, Excedrin, BC Powder, Fish Oil, Vitamin E) you take. Update this list every time you visit us, if necessary.

Name of Medicine:	Dose in msg:	When do you take it? (am/pm)	Why do you take it	Start/Stop Date

List ALL Alergies: _____

_____

Pharmacy Name and Phone Number: _____

Nurse's Initials & Date: _____