Neurosurgical Specialists of North Florida
Medical History

PATIENT REGISTRATION FORM			
Last Name:	First Name:		Middle Initial:
Mailing Address:		Age:	Gender:
City, State, Zip:		Date of Birth:	
Physical Address (if different from mailing address):		Cell #:	
Name of Primary Care Physician or Referring Office:		Home #:	
Employer or School:		Work #:	
Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Student ☐Disability ☐Unemployed		Email:	
SSN#	Language: ☐English ☐Spanish ☐Other_____	Marital:	
Race: ☐Caucasian ☐Black ☐Hispanic ☐Other_____		Ethnicity: ☐Latino/Hispanic ☐Not Latino/Hispanic ☐Refuse to Report	
Do you have a living will? ☐Yes ☐No	If yes, have you provided us with a copy? ☐Yes ☐No		
Preferred Pharmacy:		Pharmacy Phone #:	
Emergency Contact Information			
Emergency Contact Name:			
Emergency Contact Phone:		Relationship to Contact:	
Patient Contact Information			
I wish to be contacted in the following manner (check all that apply):			
☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Web Portal			
Patient Authorization / Disclosure			
☐ I consent to office leaving message with detailed information.	☐ I consent to office faxing to (____)_____ - _____		
☐ I consent to office leaving message with callback number only.			
Insurance Information			
Is this related to a Motor Vehicle Accident? ☐ Yes ☐ No	Is this related to a Workers' Comp case? ☐ Yes ☐ No		
Primary Insurance Company Name:			
Subscriber Name:		Subscriber Date of Birth:	
Subscriber Relationship to Patient:		Subscriber Employer:	
Member/Policy #:		Group #:	
Claims Mailing Address (back of card):			
Secondary Insurance Company Name:			
Subscriber Name:		Subscriber Date of Birth:	
Subscriber Relationship to Patient:		Subscriber Employer:	
Member/Policy #:		Group #:	
Claims Mailing Address (back of card):			
How did you hear about us?			
☐ Family ☐ Friend ☐ Doctor ☐ Phone Book ☐ Billboard/Sign ☐ Internet ☐ Health Fair ☐ Other_____			

I understand and agree: I authorize treatment and will be responsible for the payment of all charges incurred on behalf of myself or family member. I authorize payment of medical benefits to Neurosurgical Specialists of North Florida.

Signature _____ Date _____

PATIENT NAME_____DATE OF BIRTH_____

NEUROSURGICAL SPECIALISTS OF NORTH FLORIDA
NORTH FLORIDA REGIONAL HEALTHCARE

Neurosurgical Specialists of North Florida
Medical History

Reason for Today's Visit: _____

Allergies/Reactions

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

Hospitalizations

Hospital	Date	Reason

Social History

Alcohol Use? ☐YES ☐NO
Type _____
# of drinks per day _____
# of days per week _____
Tobacco Use (EVER)? ☐YES ☐NO
Type _____
Amount per day _____
# of years used _____
Year Quit _____
Caffeine Use? ☐YES ☐NO
Amount per day _____
Type: Coffee/ Tea/ Soda
Do you exercise? ☐YES ☐NO
Days per week _____
Hours per day _____
Type _____
Any illegal drug use? ☐YES ☐NO
Type _____

Immunizations

DATE OF IMMUNIZATION
☐ Influenza _____
☐ Pneumonia _____

Surgical History

DATE OF SURGERY
☐ Appendix _____
☐ Back/Spine _____
☐ Brain _____
☐ Breast _____
☐ Cardiac _____
☐ Cataract _____
☐ Colon _____
☐ Gallbladder _____
☐ GI _____
☐ Hernia _____
☐ Hysterectomy _____
☐ Joint _____
☐ Kidney _____
☐ Lung _____
☐ Liver _____
☐ Pacemaker/ICD _____
☐ Spleen _____
☐ Transplant _____
☐ Other _____
_____
_____

Current Medications

(Please include dosage and frequency)

_____
_____
_____
_____
_____
_____
_____
_____

PATIENT NAME_____DATE OF BIRTH_____

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Family History

	LIVING	AGE/GENDER
Mother	☐YES ☐NO	_____
Father	☐YES ☐NO	_____
Siblings	☐YES ☐NO	___/___
	☐YES ☐NO	___/___
	☐YES ☐NO	___/___
	☐YES ☐NO	___/___
Children	☐YES ☐NO	___/___
	☐YES ☐NO	___/___
	☐YES ☐NO	___/___
	☐YES ☐NO	___/___

Has any blood relative had any of the following?

	RELATIONSHIP
☐ Alcoholism	_____
☐ Aneurysm	_____
☐ Arthritis	_____
☐ Asthma	_____
☐ Breast Cancer	_____
☐ Colon Cancer	_____
☐ COPD	_____
☐ Diabetes	_____
☐ Heart Disease	_____
☐ Hypertension	_____
☐ High Cholesterol	_____
☐ Kidney Disease	_____
☐ Liver Disease	_____
☐ Lupus	_____
☐ Mental Illness	_____
☐ Migraines	_____
☐ Seizures	_____
☐ Sickle Cell	_____
☐ Stroke	_____
☐ Substance Abuse	_____
☐ Thyroid Disorder	_____
☐ Other	_____
☐ Other	_____

Medical History

Have YOU had any of the following?

☐ Anemia
☐ Aneurysm
☐ Anxiety/Depression
☐ Arthritis
☐ Asthma
☐ Atrial fibrillation
☐ Cancer _____
☐ COPD
☐ Diabetes
☐ Diverticulosis
☐ DVT
☐ Enlarged Prostate
☐ Hearing Loss
☐ Gallbladder Disease
☐ Glaucoma
☐ Gout
☐ Headaches/Migraines
☐ Heart Attack
☐ Heart Disease
☐ Heartburn
☐ Hernia
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Problems
☐ Lupus
☐ Mental Illness
☐ Neurological Disorder
☐ Seizures
☐ Sickle cell disease
☐ Stroke
☐ STI/STD
☐ Thyroid Issues ☐ Ulcers/Colitis
☐ Vascular Disease
☐ Other _____
☐ Other _____
☐ Other _____

Pain

Are you experiencing any pain? ☐YES ☐NO
Scale of 0-10: _____
Where? _____
When did the pain start? _____
What makes your pain better? _____
What makes your pain worse? _____

Home Equipment

Please check all that apply

☐ Oxygen
☐ Walker
☐ Hearing Aid
☐ Cane
☐ Glasses/contacts
☐ Wheelchair

Current Symptoms

Are you currently experiencing any of the following?

HEAD
☐ Headache
☐ Facial Pain/Numbness

NECK
☐ Neck Pain
☐ Neck Stiffness

EYES, EARS, THROAT
☐ Vision Loss
☐ Sensitivity to Light
☐ Blurred Vision
☐ Ringing in Ears
☐ Difficulty Swallowing

HEART/LUNG
☐ Chest Pains/Palpitations
☐ Shortness of breath

MUSCULOSKELETAL
☐ Joint Pain/Stiffness
☐ Muscle Aches
☐ Muscle Cramps
☐ Muscle Spasms
☐ Back Pain

NEURO/PSYCH
☐ Dizziness/Vertigo
☐ Fainting/Blacking Out
☐ Lightheadedness
☐ Memory Loss
☐ Speech Problems
☐ Balance Problems
☐ Sleep Issues
☐ Confusion
☐ Seizures
☐ Tremors
☐ Weakness
Where? _____
☐ Numbness/Tingling
Where?_____
☐ Other _____

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Review of Systems

Are you currently experiencing any of the following?

CONSTITUTIONAL
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Unintentional weight gain/loss

SKIN
- ☐ Bruising
- ☐ Dry skin
- ☐ Wound/ulcers
- ☐ Rash

EYES, EARS, NOSE, THROAT
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye pain
- ☐ Sinus problems
- ☐ Trouble swallowing
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Loss of smell

RESPIRATORY
- ☐ Wheezing
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Sleep apnea

CARDIOLOGY
- ☐ Chest pain
- ☐ Palpitations
- ☐ Swelling
- ☐ Heart murmur
- ☐ Congenital heart problems
- ☐ Pacemaker
- ☐ Irregular heart rhythm

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Nausea/vomiting
- ☐ Constiptation
- ☐ Diarrhea
- ☐ Loss of appetite
- ☐ Blood in stool

GENITOURINARY
- ☐ Painful urination
- ☐ Difficulty with urination
- ☐ Incontinence
- ☐ Frequent UTIs

MUSCULOSKELETAL
- ☐ Gait imbalance
- ☐ Weakness
  Where? _____
- ☐ Pain
  Where? _____
- ☐ Numbness/Tingling
  Where? _____

NEUROLOGY
- ☐ Confusion
- ☐ Dizziness
- ☐ Fainting spells
- ☐ Headache/migraine
- ☐ Memory loss
- ☐ Neuropathy
- ☐ Sleep problems
- ☐ Tremors
- ☐ Vertigo
- ☐ Difficulty with speech

PSYCHOLOGY
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Insomnia
- ☐ Trouble concentrating
- ☐ Suicidal thoughts

HEMATOLOGY
- ☐ Anemia
- ☐ Clotting disorders
- ☐ Bleeding disorders

ENDOCRINOLOGY
- ☐ Excessive thirst
- ☐ Intolerance to cold
- ☐ Intolerance to heat

Patient Signature _____ Date _____

Physician Signature _____ Date _____