Ira M. Garonzik, M.D.
James E. Conway, M.D., Ph.D.
H. Christopher Lawson, M.D.
Seth D. Kaufman, D.O.
James L. Frazier III, M. D.

Welcome to the Baltimore Neurosurgery and Spine Center. We ask that you take some time to complete this questionnaire in order to allow the doctor to get to know more about you and your medical condition(s). Please fill out this form prior to your visit and bring it with you on the date of your appointment. This questionnaire is confidential and will be kept as part of your medical record. If you have any questions, feel free to contact our office at (410) 664-3680.

Date of Visit: ______________________

Patient Name: ____

Are you right-handed or left-handed? Age: _________ **Height:** __________ **Weight:** ____________

Address: ____

Phone Numbers: (H) _________________ **(W)** __________________ **(Cell)** ___________________

WHO REFERRED YOU TO OUR OFFICE?

Physician Name: ____

Address: ____

Phone: ____ **Fax:** _________________________________

Specialty: ____

PLEASE LIST ALL OTHER PHYSICIANS WHO SHOULD RECEIVE A COPY OF OUR REPORT:

Name: ____

Address: ____

Phone: _______________________________________ **Fax:** __________________________________

Name: ____

Address: ____

Phone: ____ Fax:___________________________________

HISTORY OF PRESENT ILLNESS:

1. What is the reason for your visit? ____

2. How long have you had the problem? ____

3. Describe the symptoms you are experiencing: ____

4. How often do the symptoms occur? ____

5. How long do the symptoms last? ____

6. Does anything make the problem better? ____

7. Does anything make the problem worse? ____

8. Have you ever had treatment or surgery for this problem? _________________________________

9. Please rate your pain on a scale from 0 (no pain) to 10 (worst imaginable) ___________________

REVIEW OF SYSTEMS: Please circle the medical conditions below that apply to you now.

GENERAL
Weight loss or gain
Change in appetite
Altered taste or smell
Excessive sleepiness
Unable to sleep
Fatigue

EYE
Blurred vision
Double vision
Glaucoma
Cataracts

CARDIOVASCULAR
Chest pain
Angina
Fainting
Leg swelling
High blood pressure
Low blood pressure
Heart murmur
Heart failure
Heart attack

EARS, NOSE, MOUTH, THROAT
Balance problems
Snoring
Sinus disease
Mouth sores
Trouble swallowing
Sore throat
Ringing in ears
Dizziness
Hearing loss

RESPIRATORY
Emphysema
COPD
Tuberculosis
Chronic cough
Bronchitis
Pneumonia
Shortness of breath

GASTROINTESTINAL
Ulcer
Hepatitis
Vomiting
Constipation
Diarrhea
Bowel incontinence
Gastritis
Hiatal hernia
Rectal bleeding

GENITOURINARY
Kidney stones
Urinary urgency
Urinary incontinence
Sexual dysfunction
Impotence
Vaginal bleeding
Painful urination
Frequent urination
Blood in urine

PSYCHIATRIC
Depression
Anxiety
Trouble concentrating

INTEGUMENTARY
Skin rash

NEUROLOGICAL

Headache
Seizure
Loss of consciousness
Memory loss
Weakness
Trouble walking
Trouble with balance
Numbness
Tingling
Concussion
Falls
Vertigo

MUSCULOSKELETAL

Low back pain
Neck pain
Joint pain
Joint swelling

HEMATOLOGICAL
Blood disorder
Leukemia
Sickle Cell Disease
Enlarged lymph nodes
HIV

ENDOCRINE

Diabetes
Thyroid disease

PAST MEDICAL HISTORY:
Please list all current medical problems as well as major illness you have had in the past with approximate dates.

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

7. ____

8. ____

9. ____

<u>PAST SURGICAL HISTORY:</u>
Please list all operations you have had in the past with approximate dates.

1. ____
2. ____
3. ____
4. ____
5. ____

Have you ever had a problem with anesthesia? ______________________________

If yes, please explain: ______________________________

Have you ever had a blood transfusion? ______________________________

If yes, why? ______________________________

<u>MEDICATIONS</u>:
Please list all medications you are currently taking, including over the counter medications, with dosage.

1. ____________________	**6.** ____________________
2. ____________________	**7.** ____________________
3. ____________________	**8.** ____________________
4. ____________________	**9.** ____________________
5. ____________________	**10.** ____________________

Do you take aspirin or any medicines that contain aspirin? ______________________________

If yes, please specify: ______________________________

<u>ALLERGIES</u>:
Please list any known drug and/or food allergies:

1. ____
2. ____

3. ____

FAMILY HISTORY:

Please list all medical problems and current ages of the following family members. If they are deceased, please list the cause and approximate age of death.

Father: ____________________________________ **Mother:** __________________________________

Siblings: ____

Children: ____

Others: ____

SOCIAL HISTORY:

What is your highest level of education? ____

What is your occupation? ____

Are you disabled? ____

Do you smoke? _________ **If yes, how much and for how long?** _______________________________

If you quit, when did you quit? ____

Do you drink alcohol? ________ **If yes, approximately how many drinks per week?** ______________

Was the injury due to a work-related accident? ____

If yes, what was the date of injury? ____

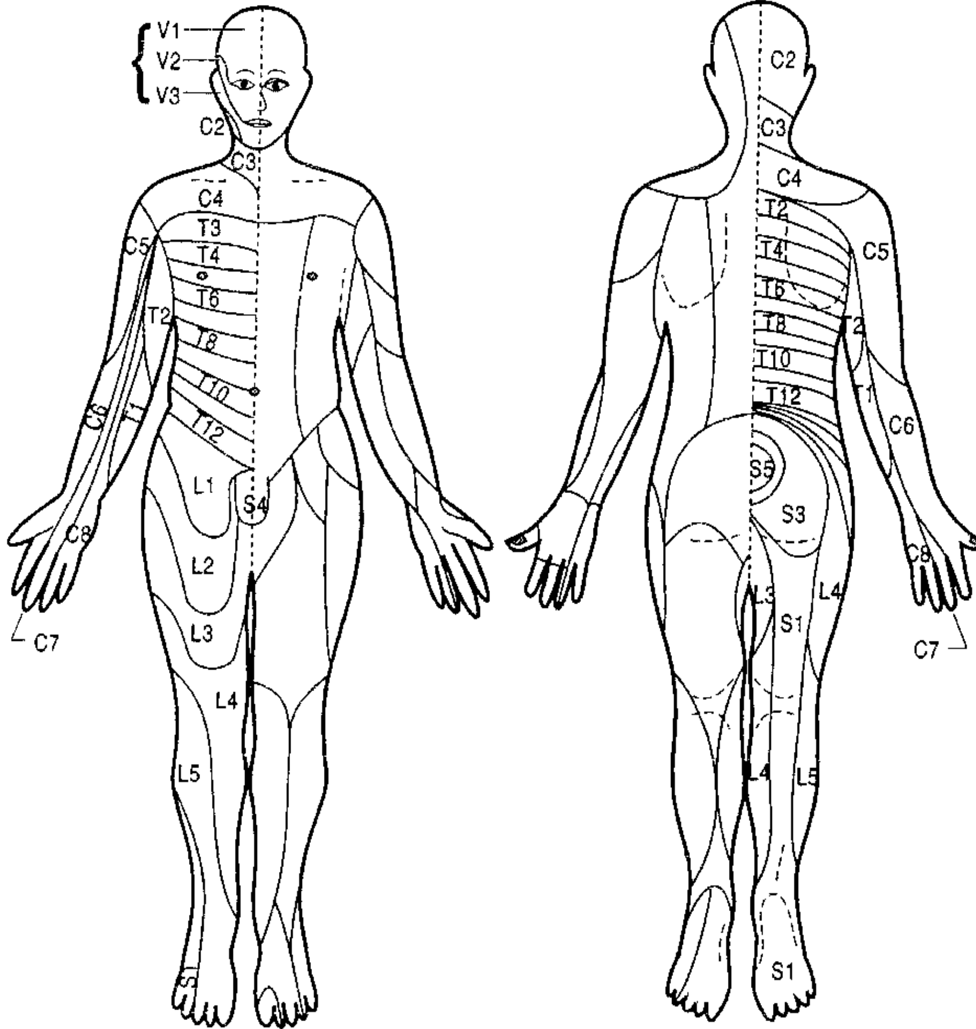
Was the injury due to an automobile accident? ____

If yes, what was the date of accident? ____

Is there any litigation involved? ____

If yes, who is your attorney? ____

Please shade the areas on these drawings where you have pain:


ANTERIOR
POSTERIOR
V1
V2
V3
C2
C3
C4
T3
T4
T6
T8
T10
T12
C5
T2
C6
T1
C8
C7
L1
S4
L2
L3
L4
L5
C2
C3
C4
T2
T4
T6
T8
T10
T12
C5
T2
T1
C6
S5
S3
C8
L3
L4
S1
C7
L4
L5
S1