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**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

**ENDOCRINE**

Diabetes  
Thyroid disease

**HEMATOLOGICAL**

Blood disorder  
Leukemia  
Sickle Cell Disease  
Enlarged lymph nodes  
HIV

**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. \_\_\_\_\_

**PAST SURGICAL HISTORY:**

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? \_\_\_\_\_

**MEDICATIONS:**

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: \_\_\_\_\_

**ALLERGIES:**

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? \_\_\_\_\_

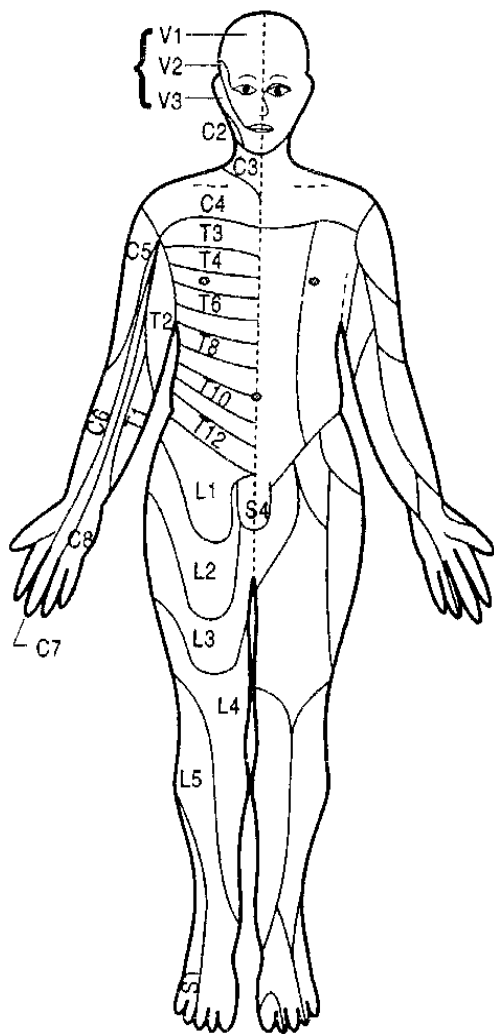
If yes, what was the date of accident? \_\_\_\_\_

Is there any litigation involved? \_\_\_\_\_

If yes, who is your attorney? \_\_\_\_\_

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

### ANTERIOR



### POSTERIOR

