ARIEL F. ABUD, M.D., L.L.C.

NEUROLOGICAL SURGERY

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Patient Name: _____ Age: _____ Date:_____

Chief Complaint: _____

HISTORY OF PRESENT ILLNESS:

Location/Associated Symptoms: _____

How long does it last, how often does it occur? _____

Precipitating Event (what caused the pain?)

Motor Vehicle Accident	Yes ____No ___	If yes, when? _____
Workman's Comp Injury	Yes ____No ___	If yes, when? _____
Liability	Yes ____No ___	If yes, when? _____

PAST MEDICAL HISTORY

Have you ever had any of the following:

Heart Attack	no yes	Alzheimer's Disease	no yes	Previous Back Problem	no yes	Peptic Ulcer	no yes
Deep Venous Thrombosis	no yes	Parkinson's Disease	no yes	Previous Neck Problem	no yes	Thyroid Disease	no yes
Varicose Veins	no yes	Epilepsy	no yes	High Blood Pressure	no yes	Bleeding Tendency	no yes
Phlebitis	no yes	Migraines	no yes	Low Blood Pressure	no yes	Depression	no yes
Lyme Disease	no yes	Tuberculosis	no yes	Hemorrhoids	no yes	Bipolar Disorder	no yes
Asthma	no yes	Diabetes Type I or II	no yes	Colitis/Crohn's Disease	no yes	Schizophrenia	no yes
Bronchitis	no yes	Cancer	no yes	HIV & AIDS	no yes	Anxiety	no yes
Pneumonia	no yes	Where? _____		Infectious Mono	no yes	Previous Head Injury	no yes
Pneumatic Fever	no yes	Glaucoma	no yes	Kidney Disease	no yes	Metal Implants	no yes
Heart Disease	no yes	Hernia	no yes	Mitral Valve Prolapse	no yes	Pacemaker	no yes
Arthritis	no yes	Blood Transfusion	no yes	Stroke	no yes	Claustrophobia	no yes
Polio	no yes	High Cholesterol	no yes	Hepatitis A, B, C, D, E	no yes	Other	no yes

PREVIOUS HOSPITALIZATIONS/SURGERIES (when & where?) : _____

_____

_____

MEDICATIONS: _____

_____

PATIENT HISTORY

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Work Status: ☐ Presently ☐ Disability ☐ Unemployed ☐ Retired
Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily
Use of Tobacco: ☐ Never ☐ Current Packs/Day ☐ #of years ☐ Quit When? _____
Use of Drugs: ☐ Never Type/Frequency:_____ Previous Abuse:_____

FAMILY MEDICAL HISTORY:

	AGE	DISEASE	If deceased, cause?
Father:	_____	_____	_____
Mother:	_____	_____	_____
Sibling(s):	_____	_____	_____

REVIEW OF SYMPTOMS: Do you PRESENTLY have any of the following?

EYES			**GENITOURINARY**			**PSYCHIATRIC**		
Wear glasses/contact lenses	no	yes	Frequent Urination	no	yes	Memory loss	no	yes
Blurred vision or double vision	no	yes	Burning or painful urination	no	yes	Confusion	no	yes
			Blood in urine	no	yes	Depression	no	yes
EARS/NOSE/THROAT/MOUTH			Female - Are you pregnant?	no	yes			
Hearing loss or ringing	no	yes				**ENDOCRINE**		
Earache or drainage	no	yes				Gland or hormone problem	no	yes
Chronic sinus problems	no	yes	**MUSCULOSKELETAL**			Excessive thirst	no	yes
Voice changes	no	yes	Joint Pain	no	yes	Excessive thirst	no	yes
Swollen glands in neck	no	yes	Where?			Excessive urination	no	yes
Sore throat	no	yes	Joint stiffness or swelling	no	yes	Heat or cold intolerance	no	yes
			Weakness or muscle/joints	no	yes			
CARDIOVASCULAR			Muscle pain/cramps	no	yes	**HEMATOLOGIC/LYMPHATIC**	no	yes
Chest pain	no	yes	Back pain	no	yes	Slow to heat	no	yes
Palpitations	no	yes	Difficulty walking	no	yes	Bleeding or bruising tendency	no	yes
Shortness of Breath	no	yes				Anemia	no	yes
Swelling feet/ankles	no	yes	**INTEGUMENTARY (skin/breast)**			Enlarged glands	no	yes
			Rash or itching	no	yes			
GASTROINTESTINAL			Breast pain	no	yes	**ALLERGIC/IMMUNOLOGIC**		
Loss of Appetite	no	yes	Breast lump	no	yes	History of skin reactions or other adverse		
Recent weight loss	no	yes	Breast discharge	no	yes	reactions to:		
Change in bowel habits	no	yes		no	yes	Penicillin	no	yes
Nausea or vomiting	no	yes	**NEUROLOGICAL**			Iodine	no	yes
Frequent diarrhea	no	yes	Frequent headaches	no	yes	Aspirin	no	yes
Painful bowel movements	no	yes	Lightheaded or dizzy	no	yes	Tetanus antitoxin	no	yes
Constipation	no	yes	Convulsions or seizures	no	yes	Sulfa	no	yes
Recent bleeding/bloody stool	no	yes	Numbness or tingling	no	yes			
Abdominal pain	no	yes	Where?			**Other Medication Allergies**		
			Tremors	no	yes	_____		
RESPIRATORY			Paralysis	no	yes			
Chronic or frequent cough	no	yes	Recent head injury	no	yes	**Known Food Allergies**		
Spitting up blood	no	yes				_____		
Shortness of breath	no	yes						
Wheezing	no	yes				_____		

To the best of my knowledge, all above questions have been answered accurately. I understand that it is my responsibility to notify Dr. Abud of any pre-existing or future medical problems because providing incorrect information may prevent proper treatment from being taken and may be dangerous to my health. I authorize Dr. Abud and staff to perform necessary services I may need.

_____ _____

Signature of Patient or Guardian Date