Appledore
MEDICAL GROUP
Coastal New Hampshire Neurosurgeons

NAME_____ **DATE OF BIRTH**_____ **DATE**_____

FAMILY PHYSICIAN_____ **REFERRING PHYSICIAN**_____

CHIEF COMPLAINT_____

ONSET OF SYMPTOMS_____ **DATE OF INJURY**_____

ARE YOU ALLERGIC TO MEDICATIONS? Yes___ No___ **LATEX/ADHESIVE?** Yes___ No___
If yes, list medications you cannot take:

_____ REACTION_____
_____ REACTION_____
_____ REACTION_____

CURRENT MEDICATIONS:

_____ DOSAGE_____
_____ DOSAGE_____
_____ DOSAGE_____
_____ DOSAGE_____
_____ DOSAGE_____
_____ DOSAGE_____

PAST MEDICAL HISTORY: Place a check next to any that apply.
□ CHILDHOOD DISEASES: _____
□ HYPERTENSION □THYROID DYSFUNCTION □ DIABETES □ SEIZURES
□ CHOLESTEROL □ MIGRAINE □ HEART ATTACK □ ANGINA □ ASTHMA
□ COPD □ KIDNEY DISEASE □ DEPRESSION □ ANXIETY □ CLAUSTROPHOBIA
□ IMPLANTED DEVICES (ie. Pacemaker/ICD, cardiac stent, vascular stent): _____
_____

OTHER PSYCHIATRIC PROBLEMS_____

List any other medical problems from which you suffer that are not included in the list from above:
_____
_____

Height_____ **Weight**_____

PROVIDER INITIALS: _____

Patient Name _____ **Date of Birth** _____

LIST SURGERY THAT YOU HAVE HAD AND THE DATE OF SURGERY:

1. SURGERY_____ DATE_____
   HOSPITAL_____

2. SURGERY_____ DATE_____
   HOSPITAL_____

3. SURGERY_____ DATE_____
   HOSPITAL_____

Other Surgeries:_____
_____
_____

SOCIAL HISTORY:

Do you do either of the following?
Smoke _____ Packs per day _____
Alcohol _____ Frequency _____

EDUCATION_____
OCCUPATION (Present or past if retired)_____
MARITAL STATUS_____ CHILDREN _____
MILITARY SERVICES_____ ACTIVE/RETIRED?_____

FAMILY HISTORY:

MOTHERS AGE_____ LIVING OR DECEASED_____ IF DECEASED, CAUSE_____
Medical problems if living_____

FATHERS AGE_____ LIVING OR DECEASED_____ IF DECEASED, CAUSE_____
Medical problems if living_____

SISTERS_____LIVING_____ DECEASED_____CAUSE_____AGE AT DEATH_____
Medical problems if living_____

BROTHERS_____LIVING_____ DECEASED_____CAUSE_____AGE AT DEATH_____
Medical problems if living_____

PATIENT'S SIGNATURE_____

PROVIDER SIGNARURE_____

COASTAL NH NEUROSURGERY

SYMPTOM SURVEY

Patient Name:_____Date:_____

Are you: Left handed or Right handed (circle one)

Please indicate below any symptoms you have been experiencing

CONSTITUTIONAL
_____ Weight loss or gain
_____ Change in appetite
_____ Fatigue
_____ Fever

EYES
_____ Cataracts
_____ Blurred vision
_____ Double vision
_____ Glaucoma

RESPIRATORY
_____ Asthma
_____ Chronic cough
_____ Tuberculosis
_____ Bronchitis
_____ Pneumonia
_____ Shortness of breath

Psychiatric
_____ Depression
_____ Anxiety
_____Trouble concentrating

Cardiovascular
_____ Chest pain or pressure
_____ Angina
_____ Fainting
_____ Leg Swelling
_____ High / Low blood pressure
_____ Heart murmur
_____ Heart failure

EARS, NOSE, MOUTH, THROAT
_____ Balance problems
_____ Ringing in ears
_____ Dizziness
_____ Nose Bleeds/discharge
_____ Hearing loss
_____ Sinus disease
_____ Mouth sores
_____ Trouble swallowing

MUSCULOSKELETAL
_____ Low back pain
_____ Neck pain
_____ Joint pain
_____ Joint swelling
_____ Arthritis (Diagnosed)

Integumentary
_____ Skin rashes
_____ Psoriasis

Endocrine
_____ Thyroid disease
_____ Diabetes

Hemo-lymphatic
_____ Blood disorder
_____ Enlarged lymph nodes
_____ HIV/AIDS

Gastrointestinal
_____ Diarrhea
_____ Hepatitis
_____ Abdominal pain
_____ Vomiting
_____ Constipation

Genitourinary
_____ Blood in urine
_____ Urinary urgency
_____ Urinary incontinence
_____ Sexual dysfunction
_____ Frequent urination

Neurologic
_____ Seizures
_____ Loss of conciousness
_____ Headache
_____ Memory Loss
_____ Trouble walking
_____ Trouble with balance
_____ Numbness _____(LOC)
_____ Tingling _____(LOC)
_____ Falls
_____ Concussion
_____ Weakness

1. Have any of your immediate family members had heart disease? [ ]YES [ ] NO
2. Have any of your immediate family members had diabetes? [ ]YES [ ] NO
3. Have you recently started an exercise program? [ ]YES [ ] NO
4. Have you fallen in the last year due to dizziness or vertigo? [ ]YES [ ] NO
5. Have you gotten dizzy after standing up quickly on multiple occasions? [ ]YES [ ] NO

Patient Sign_____Date_____

Physician Sign:_____ Date:_____Reviewed on:_____