Dartmouth Health — Alice Peck Day Memorial Hospital **NEW PATIENT PACKET** **Neurosurgery Services**	MRN: NAME: Two identifiers needed DOB:

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Please complete all pages of this medical history form before reporting for your examination.

Date:_____

Name:_____

DOB:_____ Age:_____ Sex: ☐Male ☐Female

Handedness: ☐Left ☐Right Height:_____ Current Weight:_____

For what problem are you being referred to this office:_____

_____

_____

Do you believe that this problem is work related: ☐Yes ☐No If yes, explain:_____

_____

_____

Did this problem begin after an injury: ☐Yes ☐No If yes what kind of injury:_____

_____

_____

The problem is: ☐Constant ☐Comes and Goes ☐Improved ☐Worse

_____

Dartmouth Health | Alice Peck Day Memorial Hospital

NEW PATIENT PACKET
Neurosurgery Services

MRN:

NAME: Two identifiers needed

DOB:

Medical History (do you have any of the following medical conditions):

CONDITION	YES	NO	YEAR DIAGNOSED	WHAT TYPE
High Blood Pressure				
High Cholesterol				
Depression				
Diabetes				
Asthma				
Sleep Apnea				
Irregular Heart Rate				
Migraine Headaches				
Seizures/Epilepsy				
Arthritis				
Lung Disease				
Kidney Disease				
Thyroid Disease				
Skin Disease				
Liver/Intestine Disease				
Cancer				

Do you have Heart Disease? ☐Yes ☐No What Type:_____

Cardiologist:_____ Last Cardiology Appt:_____

Other Conditions:_____

_____

Have you ever had any of the following?

CONDITION	YES	NO	WHEN (YEAR)
Heart Attack			
Heart Bypass Surgery			
Neck Injury			
Back Injury			
Stroke			
Head Injury			
Car Accident			

Surgical History (please list all previous surgeries that you have had – please use back if additional surgeries):

1)_____ When?_____ Where?_____

2)_____ When?_____ Where?_____

3)_____ When?_____ Where?_____

4)_____ When?_____ Where?_____

5)_____ When?_____ Where?_____

Social History:

Occupation (if retired, list previous job):_____

Social History (continued):

Tobacco use: ☐Never smoked cigarettes/cigar

☐Used to smoke _____ packs per day but quit in (year) _____

☐Currently smoke _____ packs per day, started smoking at age _____

Do you use: Chewing Tobacco: ☐Yes ☐No

E-Cigarette: ☐Yes ☐No

Vaporizer: ☐Yes ☐No

Alcohol use: ☐Have never used alcohol ☐Drink occasionally ☐Drink daily

☐Quit drinking in:_____

I usually drink: ☐Beer ☐Wine ☐Mixed Drinks

And I usually have _____ drinks in one day.

Family History:

Are you adopted? ☐Yes ☐No

Mother: ☐Alive ☐Deceased Age:_____

Cause of death if deceased:_____

Father: ☐Alive ☐Deceased Age:_____

Cause of death if deceased:_____

Age of brothers: _____ _____ _____ If deceased, indicate age at time:_____

Age of sisters: _____ _____ _____ If deceased, indicate age at time:_____

Family History (continued):

Age of children: _____ _____ _____

Do/did any of these family members have any of the following medical conditions:

CONDITION	YES	NO	WHO (Mother, Father, Sister, Brother, Etc.)
High Blood Pressure			
Migraine Headaches			
Alzheimer's Disease			
Multiple Sclerosis			
Heart Attack			
Diabetes			
Seizures			
Tremors			
Stroke			
Carpal Tunnel Syndrome			

Other Conditions:_____

Who:_____

Medications:

Allergies (please list medications that you are allergic to):_____

_____

_____

Medications (continued):

Please list seasonal or environmental allergies:_____

_____

Current Medications (please list all your current medications and supplements with dosages and how you take them or attach medication list from your pharmacy):

Medication	Dosage	How is it Taken	Why do you take it?
Example: Advil	200mg	2 tablets every 8 hours	Pain

Form Completed by:_____ Date:_____/_____/_____

Reviewed with Patient By:_____ Date:_____/_____/_____