

Alice Peck Day Memorial Hospital MRN: NAME:

DOB:

Two identifiers needed

NEW PATIENT PACKET Neurosurgery Services

Hulda B. Magnadottir, M.D. Board Certified in Neurological Surgery Harold J. Pikus, M.D. Board Certified in Neurological Surgery

Alyssa M. Pearl, PA-C Board Certified by NCCPA Patrick A. Schembri, PA-C Board Certified by NCCPA

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

Date:					
Name:					
DOB:		Age:		Sex: Male	e Female
Handedness:	Left Ri	ght Heig	ıht:	Currei	nt Weight:
For what problem	are you being referre	ed to this offic	e:		
Do you believe that	at this problem is wor	k related:	Tes	No	If yes, explain:
	·				, , , , <u> </u>
Did this problem b	egin after an injury:	TYes	No	lf ves what k	ind of injury:
				ii yoo iinar k	
The problem is:	Constant		and Goes	Improved	Worse
				p.c.ou	



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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:		Las	st Cardiology Appt:	
Page 2 of 6				



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Other Conditions:

Have you ever had any of the following?

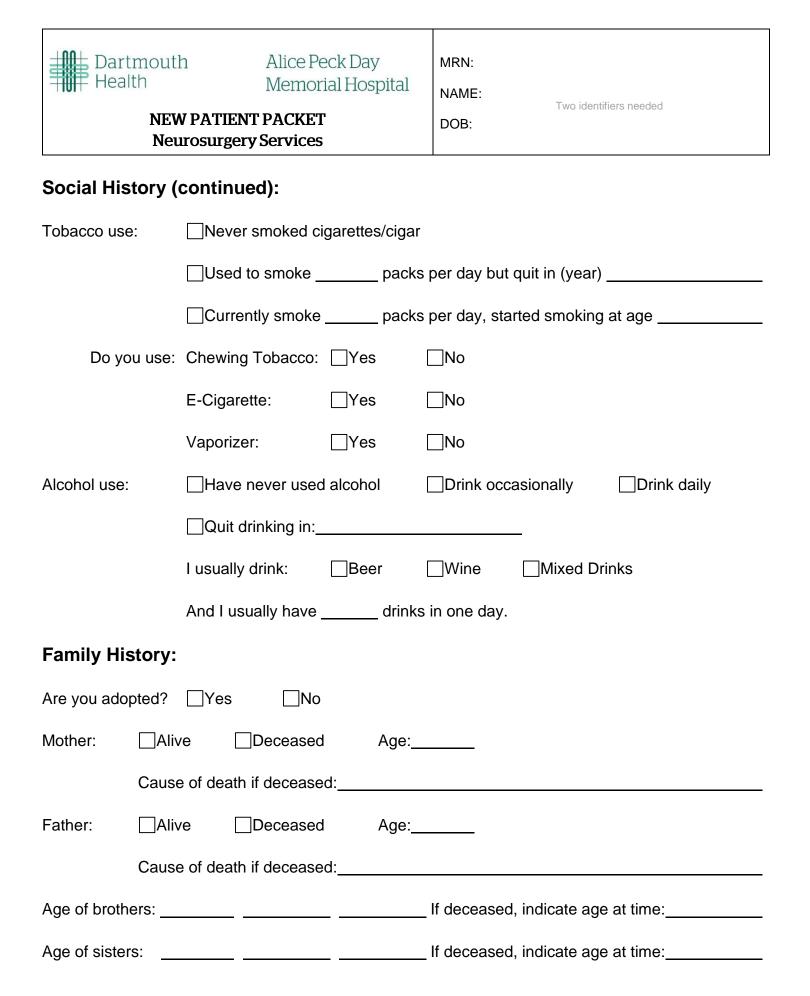
CONDITION	YES	NO	WHEN (YEAR)
Heart Attack			
Heart Bypass Surgery			
Neck Injury			
Back Injury			
Stroke			
Head Injury			
Car Accident			

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):





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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):



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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:	/	<u>/</u>
Reviewed with Patient By:	Date:	<u>/</u>	/
Page 6 of 6			