THE KANSAS CITY NEUROSURGERY GROUP, LLC

Name ___________________________________

Date ___________________________________

Referred by: ___________________________________

Primary Care Physician: ___________________________________

Age: _______________ Marital Status: _______________________

Occupation: ___________________________________

What is the **main symptom or problem** for which you are seeking treatment today?

____

____

How long have these symptoms been present?

____

Operations/Hospitalizations (not including pregnancies):

Reason	Year
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Current Medications (please include prescription and non-prescription)

Medication	Dosage	Schedule

Medication Allergies: ___________________________________

____

Please check the appropriate box(es):

Medical History	Self	Parents	Siblings
Alcoholism			
Arthritis/Gout			
Asthma			
Bleeding disorder			
Blood transfusions			
Cancer			
Colon trouble			
Depression			
Diabetes			
Dizzy spells			
Emphysema/black lung			
Epilepsy/Seizures			
Gastrointestinal changes:			
Constipation			
Incontinence			
Glaucoma			
HIV/AIDS			
Heart attack/trouble			
Hearing changes			

Medical History	Self	Parents	Siblings
Hernia			
High blood pressure			
High cholesterol			
Jaundice/liver disease			
Kidney disease/stones			
Kidney/bladder infection			
Mental illness			
Migraine/headaches			
Pneumonia			
Rheumatic fever			
Stomach/duodenal ulcer			
Stroke			
Thyroid disease			
Tuberculosis			
Urinary changes:			
Retention			
Incontinence			
Sexual dysfunction			
Visual Changes			

Social History:	N	Y	Freq.
Alcohol			# per week:
Coffee			# per day:
Soda			# per day:
Tea			# per day:
Tobacco			Pk per day:

Which is your predominant hand? (please circle one)

Right Left

☐ Please check here if you are or think you might be pregnant currently