St. Joseph Medical Group

## Neurosurgery

# FEMALE PATIENT HISTORY FORM

Date _____

Name_____ _____ _____
First MI Last

Birthdate_____

Pharmacy Name, Location, Phone Number

_____

_____

**MEDICAL HISTORY/ILLNESS**

Do you currently or have you ever had any of the following (please check all that apply).

| | | |
|---|---|---|
| ☐ Acid Reflux | ☐ Gout | ☐ Nasal Allergies |
| ☐ Alzheimer's/Parkinson's | ☐ Gynecological Problems | ☐ Osteoporosis |
| ☐ Anemia | ☐ Heart Attack/Angia | ☐ Pacemaker/Valve Surgery |
| ☐ Arthritis/joint problems | ☐ Heart disease | ☐ Problems with anesthesia |
| ☐ Asthma | ☐ Heart murmur | ☐ Rheumatic/scarlet fever |
| ☐ Bleeding/clotting | ☐ Heart rhythm problems | ☐ Seizure disorder |
| ☐ Blood clots in legs/lungs | ☐ High/low blood pressure | ☐ Sexually Transmitted Disease |
| ☐ Bone disorder | ☐ High cholesterol | ☐ Skin problems |
| ☐ Bronchitis/emphysema | ☐ Irritable bowel disease | ☐ Stomach ulcers or bleeding |
| ☐ Cancer/Leukemia | ☐ Kidney failure | ☐ Stroke |
| ☐ Colitis/diverticulitis | ☐ Kidney disease/stones | ☐ Thyroid disease/goiter |
| ☐ Cystic Fibrosis | ☐ Liver disease/hepatitis/cirrhosis | ☐ Tuberculosis |
| ☐ Depression/anxiety/panic | ☐ Lupus/rheumatoid arthritis | Please indicate whether you have taken any aspirin or aspirin-like products (Motrin, Advil) in the last 10 days. ○ Yes ○ No |
| ☐ Diabetes pills only OR Insulin dependent | ☐ Migraine headache | |
| ☐ Glaucome/cataract | ☐ Multiple sclerosis | |

**PAST SURGICAL HISTORY**

| Year | Problem/Surgery | Hospital | Physician |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please provide information regarding the physician referring you for neurological evaluation.
Dr. _____ Phone _____
Address _____

Please provide information regarding your primary care physician.
Dr. _____ Phone _____
Address _____

Have you ever had an exam by cardiologist? ○ No ○ Yes
If yes, what was the physician name: _____
What was the reason for the exam: _____

Have you ever had an electrocardiogram? ○ No ○ Yes
If yes, what was the physician name: _____
What was the reason for the exam: _____

Do you still menstruate? ○ N/A ○ Yes ○ No
If no, what was your age of menopause? _____
If applicable, date of last mammogram/breast exam? _____Last pelvic exam? _____

**MEDICATION HISTORY**

Drug allergies and intolerances:
_____
_____

Current Medications – including inhalers, vitamins & herbal supplements

| **Name** | **Dose** | **Times/Day** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**VACCINATION HISTORY**

Check those that you were vaccinated for.

| | | | |
|---|---|---|---|
| ☐ Pneumonia | ☐ Flu | ☐ Hepatitis | ☐ Meningitis |
| ☐ Polio | ☐ Small pox | ☐ Measles | ☐ Mumps |
| ☐ Rubella | ☐ Hemophylus | ☐ German Measles | |
| TB Skin Test:<br>○ Positive ○ Negative | | Tetanus series dates:<br>_____ | |

**SOCIAL HISTORY**

What is your marital status? ○ Married ○ Divorced ○ Single ○ Widowed ○ Separated

If you have children, what are their ages? _____

What is your living situation? ○ live alone ○ with spouse ○ with significant other ○ with other family ○ other living arrangements: _____

Do you drink alcohol? ○ No ○ Yes

If yes, what type(s), how much, and how often?

_____

Do you smoke or use tobacco products? ○ No ○ Yes

If yes, what type(s), how much, and how long have you used this product?

_____

Do you use recreational drugs? ○ No ○ Yes

If yes, what type(s), how much, and how often?

_____

Do you drink caffeinated drinks? ○ No ○ Yes

Do you wear seat belts? ○ No ○ Yes

Do you exercise regularly? ○ No ○ Yes

Do you use any form of contraception? ○ No ○ Yes ○ N/A

Are you currently or have you been exposed to chemical, toxins, poisons, fumes, smoke, and/or radioactive materials at home or work? ○ No ○ Yes

What is your work/job? _____

**FAMILY HISTORY**

☐ Please check here if you are adopted or have an unknown history. You may skip this section.

| Relation | Age | State of health | Age of death | Cause of death | Check if your blood relatives has/had any of the following: |
|---|---|---|---|---|---|
| Father | | | | | ☐ Alcoholism |
| Mother | | | | | ☐ Arthritis/gout |
| Brother(s) | | | | | ☐ Asthma/hay fever |
| | | | | | ☐ Cancer/leukemia |
| | | | | | ☐ Bleeding disorders |
| Sister(s) | | | | | ☐ Clotting disorder |
| | | | | | ☐ Diabetes |
| | | | | | ☐ Heart disease |
| Grandparents | | | | | ☐ High blood pressure |
| | | | | | ☐ Kidney disease |
| | | | | | ☐ Muscle/bone disorder |
| | | | | | ☐ Stroke |
| Uncles | | | | | ☐ Thyroid |
| Aunts | | | | | ☐ Tuberculosis |
| Cousins | | | | | ☐ Other disease/disorder |

Additional writing space or other information you'd like to share with us:

**CURRENT SYMPTOMS**

Please check if you are experiencing any of the following symptoms:

| | | | |
|---|---|---|---|
| ☐ Abdominal pain | ☐ Difficulty urinating | ☐ Headache | ☐ Painful intercourse |
| ☐ Appetite loss | ☐ Difficulty breathing | ☐ Hives | ☐ Petechiae |
| ☐ Back pain | ☐ Dizziness | ☐ Hoarseness | ☐ Poor circulation |
| ☐ Black/tarry stools | ☐ Double or blurry vision | ☐ Irregular or fast heartbeat | ☐ Rash |
| ☐ Bleeding between periods | ☐ Earache with/without drainage | ☐ Joint pain | ☐ Shortness of breath |
| ☐ Blood in stool | ☐ Easy bruising | ☐ Loss of bladder control | ☐ Sleep disturbance |
| ☐ Blood in urine | ☐ Excessive hunger | ☐ Loss of bowel control | ☐ Swallowing problem |
| ☐ Bloody cough | ☐ Excessive menstrual bleeding | ☐ Moles | ☐ Swelling of feet/legs |
| ☐ Bloody vomiting | ☐ Excessive phlegm | ☐ Muscle ache | ☐ Swollen glands/nodes |
| ☐ Breast lumps | ☐ Excessive thirst | ☐ Nausea | ☐ Vaginal discharge |
| ☐ Chest pain | ☐ Excessive urination | ☐ Night sweats | ☐ Varicose veins |
| ☐ Chills | ☐ Fainting | ☐ Nipple discharge | ☐ Vomiting |
| ☐ Chronic cough | ☐ Fatigue | ☐ Non-healing sores | ☐ Weakness |
| ☐ Constipation | ☐ Fever | ☐ Nose bleed | ☐ Weight gain (unexplained) |
| ☐ Diarrhea | ☐ Genital lesions | ☐ Numbness | ☐ Weight loss |
| | | | ☐ Wheezing |

I hereby acknowledge that the above information is accurate and true to best of my knowledge. I understand that there may be legal penalties for intentionally providing false information. I understand that this document will become part of my permanent medical record.

SIGNATURE: _____ DATE: _____

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to serve in the place of the original.

SIGNATURE: _____ DATE: _____

**INSURANCE REQUIREMENTS**

IT IS THE PATIENT'S RESPONSIBILITY TO PROVIDE ACCURATE INSURANCE COVERAGE INFORMATION

Your insurance card(s) and the appropriate copayment must be presented at the time of each visit. A claim for professional services will be submitted to your insurance company on your behalf if you have provided accurate information. If we are unable to verify your coverage or if we determine that your insurance information is not valid, we will bill you directly for the total charge of any unpaid services. For your convenience, we accept credit/debit cards, cash and checks as methods of payment.

SIGNATURE: _____ DATE: _____