FEIGENBAUM NEUROSURGERY

Frank Feigenbaum, M.D., FAANS, FACS

PATIENT HISTORY

Name_____Phone_____Birth Date_____Age____Sex____Date_____

Who requested that you see our physician? _____ Phone_____

How did you find us: ☐ Internet, name of website/search engine: _____ ☐ Tarlov Cyst Foundation

Did you refer yourself? ☐ Yes ☐ No ☐ Other explain: _____

Family Physician or Internist: _____ Phone_____

What is your major problem or complaint? _____

When did your problem start? _____ Was there a specific injury? _____ Date of Injury _____

DO YOU CONSIDER THIS A WORK OR AUTO RELATED INJURY? _____ Why? _____

Have you seen other doctors for this problem? _____ Who? _____

PAST MEDICAL HISTORY (check all present): ☐ MEDICAL HISTORY NEGATIVE

Cardiovascular (heart):
☐ Hypertension (high blood pressure)
☐ Coronary artery disease / Heart disease
☐ Deep Vessel Thrombosis (DVT/blood clots/congenital clotting factor deficiency)
☐ Atrial fibrillation / Irregular heart rhythm–type_____
☐ Heart valve problems
☐ Cardiac stents
☐ Congestive heart failure
☐ Peripheral vascular disease
☐ Pace maker / Defibrillator

Respiratory:
☐ COPD/emphysema
☐ Asthma
☐ Seasonal allergies
☐ Sleep apnea / CPAP/BiPAP
☐ Pulmonary embolism
☐ Lung disease: _____

Gastrointestinal:
☐ Hepatitis / Liver disease
☐ Peptic/gastric ulcer
☐ GERD (reflux)
☐ Colon/Rectal: _____
☐ Irritable Bowel Syndrome

Metabolic:
☐ Diabetes: Type I / Type II
☐ Thyroid disorder
☐ Hyperlipidemia (high cholesterol)
☐ Obesity

Musculoskeletal:
☐ Rheumatoid arthritis
☐ Gout
☐ Fibromyalgia
☐ Osteoarthritis
☐ Osteoporosis

Cancer:
Indicate type, treatment, year
☐ Breast: Right/ Left _____
☐ Colon _____
☐ Lung _____
☐ Prostate _____
☐ Other: _____

Connective Tissue Disease:
☐ Marfan's
☐ Ehlers-Danlos syndrome
☐ Other: _____

Renal (kidney):
☐ Kidney failure
☐ Removal of kidney
Right / Left
☐ Dialysis
☐ Other: _____

Neurologic / Psychiatric:
☐ Stroke
☐ Seizures: last seizure_____
☐ Trauma
☐ Head injury
☐ Anxiety disorder
☐ Bi-polar disorder
☐ Depression
☐ Dementia
☐ Migraine headaches
☐ Multiple Sclerosis
☐ Peripheral neuropathy
☐ Parkinson's disease
☐ Hereditary defects
☐ Spinal cord stimulator implant

Infectious:
☐ HIV / AIDS
☐ Shingles
☐ Methicillin resistant staph aureus (MRSA)

Other:
☐ Chronic kidney/renal disease
☐ Glaucoma
☐ Anemia
☐ Other: _____

PAST SURGICAL HISTORY: *INCLUDE DATE(S)*

☐ NO PRIOR SURGERIES ☐ Tonsillectomy _____ ☐ Appendectomy (appendix) _____	☐ C-Section _____ ☐ D&C _____ ☐ Hysterectomy_____

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AIMIS Spine: Theodorou Potamianou 50, Kato Polemidia 4155, Limassol, Cyprus
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☐ Cholecystectomy (gallbladder) _____
☐ Vasectomy _____
☐ Tubal ligation _____

☐ Other surgery:_____

☐ Other surgery:_____

☐ Other surgery:_____

☐ Heart _____ ☐ Stents ☐ Ablation
☐ Spine surgery ☐ Neck ☐ Mid-back ☐ Lower back
Neck _____ Mid-back _____ Lower _____
Do you have metal in your body? Yes / No
If yes, is it MRI compatible (titanium)? Yes / No

Have you had any problems with anesthesia with previous surgeries? Yes / No **If so, explain:** _____

Have you or anyone in your family had a reaction to anesthesia called Malignant Hyperthermia? Yes / No **If so, who:** _____

DISEASES THAT RUN IN THE FAMILY/FAMILY MEDICAL HISTORY: (include deceased family members):

Disease	Father	Mother	Brother	Sister	Other (specify)
Heart Disease					
Diabetes					
Hypertension (high blood pressure)					
High Cholesterol					
Cancer (specify/type)					
Hereditary Defects					
Other					

☐ **Adopted** ☐ **Family history unobtainable** ☐ **Family history negative**

REVIEW OF SYSTEMS (check all present): **ALL OTHER SYSTEMS NEGATIVE**

Constitutional:
☐ Chills
☐ Fatigue
☐ Fever
☐ Weight gain _____lbs
☐ Weight loss _____lbs
☐ Night sweats

Eye:
☐ Blurry vision
☐ Seeing double
☐ Vision problems
☐ Eye discharge

Ear Nose Throat:
☐ Earache
☐ Hoarseness
☐ Loss of Hearing
☐ Nasal Congestion
☐ Ringing in Ears
☐ Sinus Pain
☐ Sore throat
☐ Ear discharge
☐ Nasal discharge
☐ Sinus pressure

Cardiovascular:
☐ Chest Pain
☐ Edema (leg swelling)
☐ Palpitations (irregular heart beat)
☐ Paroxysmal nocturnal dyspnea (shortness of breath, coughing at night)

Endocrine:
☐ Excessive thirst
☐ Intolerance to cold
☐ Intolerance to heat

Respiratory:
☐ Cough
☐ Coughing up Sputum
☐ Short of breath
☐ Wheezing
☐ Home oxygen use (___L)
☐ Coughing up blood

Gastric:
☐ Abdominal pain
☐ Constipation
☐ Decreased appetite
☐ Diarrhea
☐ Difficulty swallowing

(Gastric continued)
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Rectal bleeding
☐ Black stools

Urinary:
☐ Dysuria (pain on urination)
☐ Hematuria (blood in urine)
☐ Nocturia (more than 2 urinations during night)
☐ Urinary frequency
☐ Urinary incontinence
☐ Urinary retention

Female Genital Symptoms:
☐ Decreased libido
☐ Heavy periods
☐ Irregular menses
☐ No menses > 6 months
☐ Painful intercourse
☐ Painful periods
☐ Vaginal discharge
☐ Private area numbness
☐ Private area pain

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Male Genital Symptoms: ☐ Erectile disorder ☐ Penile discharge ☐ Terminal drippling ☐ Testicular lump ☐ Urinary hesitancy ☐ Small urine stream ☐ Private area numbness	Breast: ☐ Discharge ☐ Lump	Psych: ☐ Anxiety ☐ Depression
☐ Private area pain	Neuro: ☐ Headache ☐ Dizziness ☐ Fainting ☐ Memory Loss ☐ Numbness / Tingling ☐ Claustrophobia ☐ Sleep disturbances ☐ Low back pain ☐ Sacral pain ☐ Difficulty walking ☐ Difficulty sitting ☐ Paralysis	Hematologic /Lymph: ☐ Anemia ☐ Excessive bleeding during surgery ☐ Easy bruising ☐ Swollen glands in the neck
Musculoskeletal: ☐ Joint pain ☐ Joint swelling ☐ Muscle aches ☐ Muscle weakness		Immune System: ☐ Auto-immune disease ☐ Seasonal allergies ☐ Allergic reaction to medication(s) ☐ Recurrent infections
Integument: ☐ Skin rash / Lesions		
☐ REVIEW OF SYSTEMS NEGATIVE		

Do you drink alcohol excessively?_____Do you use drugs?_____Have you been treated for substance abuse?_____

Do you smoke now?_____Packs per day?_____How long?_____Have you in the past?____When did you quit?_____

Race: ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Hawaiian or Other Pacific Islander ☐ Other Race ☐ White ☐ Decline to specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to specify

Preferred Language: _____

If 65 years or older: Fall Risk (using FRAT Pack Assessment Tool)

RISK FACTOR	LEVEL	RISK SCORE
RECENT FALLS	None in last 12 months One or more between 3 & 12 months ago One or more in last 3 months One or more in last 3 months whilst inpatient/resident	2 4 6 8
MEDICATIONS (Sedatives, Anti-Depressants, Anti-Parkinson's, Diuretics, Anti-hypertensives, hypnotics)	Not taking any of these Taking one Taking two Taking more than two	1 2 3 4
PSYCHOLOGICAL (Anxiety, Depression, Decreased Cooperation, Decreased Insight or Judgment esp. re: mobility)	Does not appear to have any of these Appears mildly affected by one or more Appears moderately affected by one or more Appears severely affected by one or more	1 2 3 4
COGNITIVE STATUS	Intact Mildly impaired Moderately impaired Severely impaired	1 2 3 4
RISK SCORE (Low Risk: 5-11 Medium Risk: 12-15 High Risk: 16-20)		_____/20

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Have you had a flu vaccine within the past year? ☐ Yes ☐ No If No, Reason_____

If 65 years or older of age, have you ever had a pneumonia vaccination? ☐ Yes ☐ No ☐ N/A If No, Reason_____

Women, ages 21-64, have you received one or more pap tests to screen for cervical cancer? ☐ Yes ☐ No ☐ N/A

Women, ages 40-69, have you had a mammogram in the past 2 years? ☐ Yes ☐ No ☐ Mastectomy ☐N/A

If 50-75 years of age, have you had a complete colonoscopy in the past 10 years? ☐ Yes ☐ No ☐ N/A

Marital Status _____ **Number of children** _____ **Do you have a healthcare directive or power of attorney?** ☐ Yes ☐ No **If No, would you like more information?** ☐ Yes ☐ No

Occupation _____ **Height** _____ **Weight** _____

MEDICATIONS YOU ARE TAKING (include dose, prescription, over the counter drugs, vitamins, herbals, etc.): ☐ Not currently taking any medications

Medication Name	Dosage / Amount / Frequency	Reason for Taking	Prescribing Doctor

Preferred Pharmacy: _____ **Phone:** _____

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DRUG ALLERGIES AND REACTIONS: ☐ **No Known Drug Allergies**

Medication Name	True Allergy (facial swelling, airway tightening, hives)	Adverse Reaction (nausea, vomiting, upset stomach, headache)	Date

Allergy to: ____ Latex ____Betadine ____Shellfish ____ IV Contrast/Dye **Reaction:**_____

For Office Use Only:	
Pulse:_____	BP:_____/_____

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