



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)

<input type="checkbox"/> NO PRIOR SURGERIES	<input type="checkbox"/> C-Section _____
<input type="checkbox"/> Tonsillectomy _____	<input type="checkbox"/> D&C _____
<input type="checkbox"/> Appendectomy (appendix) _____	<input type="checkbox"/> Hysterectomy _____

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<input type="checkbox"/> Cholecystectomy (gallbladder) _____ <input type="checkbox"/> Vasectomy _____ <input type="checkbox"/> Tubal ligation _____ <input type="checkbox"/> Other surgery: _____ <input type="checkbox"/> Other surgery: _____ <input type="checkbox"/> Other surgery: _____	<input type="checkbox"/> Heart _____ <input type="checkbox"/> Stents <input type="checkbox"/> Ablation <input type="checkbox"/> Spine surgery <input type="checkbox"/> Neck <input type="checkbox"/> Mid-back <input type="checkbox"/> 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: _____
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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 (<i>specify/type</i>)					
Hereditary Defects					
Other					
<input type="checkbox"/> Adopted <input type="checkbox"/> Family history unobtainable <input type="checkbox"/> Family history negative					

REVIEW OF SYSTEMS (check all present):

ALL OTHER SYSTEMS NEGATIVE

<u>Constitutional:</u> <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Weight gain _____ lbs <input type="checkbox"/> Weight loss _____ lbs <input type="checkbox"/> Night sweats	<u>Cardiovascular:</u> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Edema (leg swelling) <input type="checkbox"/> Palpitations (irregular heart beat) <input type="checkbox"/> Paroxysmal nocturnal dyspnea (shortness of breath, coughing at night)	<u>(Gastric continued)</u> <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Black stools
<u>Eye:</u> <input type="checkbox"/> Blurry vision <input type="checkbox"/> Seeing double <input type="checkbox"/> Vision problems <input type="checkbox"/> Eye discharge	<u>Endocrine:</u> <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Intolerance to cold <input type="checkbox"/> Intolerance to heat	<u>Urinary:</u> <input type="checkbox"/> Dysuria (pain on urination) <input type="checkbox"/> Hematuria (blood in urine) <input type="checkbox"/> Nocturia (more than 2 urinations during night) <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Urinary retention
<u>Ear Nose Throat:</u> <input type="checkbox"/> Earache <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Sore throat <input type="checkbox"/> Ear discharge <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Sinus pressure	<u>Respiratory:</u> <input type="checkbox"/> Cough <input type="checkbox"/> Coughing up Sputum <input type="checkbox"/> Short of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Home oxygen use (___L) <input type="checkbox"/> Coughing up blood	<u>Female Genital Symptoms:</u> <input type="checkbox"/> Decreased libido <input type="checkbox"/> Heavy periods <input type="checkbox"/> Irregular menses <input type="checkbox"/> No menses > 6 months <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Painful periods <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Private area numbness <input type="checkbox"/> Private area pain
<u>Gastric:</u> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Constipation <input type="checkbox"/> Decreased appetite <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty swallowing		

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

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: _____

Have you had a flu vaccine within the past year? Yes No 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** _____

