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
- ☐ Myocardial Infarction: last known _____

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: Hypothyroid / Hyperthyroid
- ☐ 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: last known _____, last recommended change _____
- ☐ 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: _____
- ☐ Other: _____

Main Office: 11970 N Central Expressway • Suite 460 • Dallas, Texas 75243
AIMIS Spine: Theodorou Potamianou 50 • Kato Polemidia 4155 • Limassol, Cyprus
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Name _____ Phone _____ Birth Date _____ Age ___ Sex ___ Date _____

PAST SURGICAL HISTORY: *INCLUDE DATE(S)*

☐ NO PRIOR SURGERIES
☐ Tonsillectomy _____
☐ Appendectomy (appendix) _____
☐ Cholecystectomy (gallbladder) _____
☐ Vasectomy _____
☐ Tubal ligation _____
☐ C-Section _____
☐ D&C _____
☐ Hysterectomy _____
☐ Heart _____ ☐ Stents ☐ Ablation
☐ Spine surgery If yes, which level? ☐ Neck ☐ Mid-back ☐ Lower back

Neck _____ Mid-back _____

Lower _____

☐ Other surgery:_____

☐ Other surgery:_____

☐ Other surgery:_____

Do you have 'restrictive extremity'? Yes / No **If yes, which limb?** _____

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**

- **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:** _____
- **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** _____
- **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 _____

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Name _____ Phone _____ Birth Date _____ Age ___ Sex ___ Date _____

- **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

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

<table>
<tr>
<td>Constitutional:
☐ Chills
☐ Fatigue
☐ Fever
☐ Weight gain _____lbs
☐ Weight loss _____lbs
☐ Night sweats</td>
<td>Cardiovascular:
☐ Chest Pain
☐ Edema (leg swelling)
☐ Palpitations (irregular heart beat)
☐ Paroxysmal nocturnal dyspnea (shortness of breath, coughing at night)</td>
<td>(Gastric continued)
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Rectal bleeding
☐ Black stools</td>
</tr>
<tr>
<td>Eye:
☐ Blurry vision
☐ Seeing double
☐ Vision problems
☐ Eye discharge</td>
<td>Endocrine:
☐ Excessive thirst
☐ Intolerance to cold
☐ Intolerance to heat</td>
<td rowspan="2">Urinary:
☐ Dysuria (pain on urination)
☐ Hematuria (blood in urine)
☐ Nocturia (more than 2 urinations during night)
☐ Urinary frequency
☐ Urinary incontinence
☐ Urinary retention</td>
</tr>
<tr>
<td rowspan="2">Ear Nose Throat:
☐ Earache
☐ Hoarseness
☐ Loss of Hearing
☐ Nasal Congestion
☐ Ringing in Ears
☐ Sinus Pain
☐ Sore throat
☐ Ear discharge
☐ Nasal discharge
☐ Sinus pressure</td>
<td>Respiratory:
☐ Cough
☐ Coughing up Sputum
☐ Short of breath
☐ Wheezing
☐ Home oxygen use (___L)
☐ Coughing up blood</td>
</tr>
<tr>
<td>Gastric:
☐ Abdominal pain
☐ Constipation
☐ Decreased appetite
☐ Diarrhea
☐ Difficulty swallowing</td>
<td>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</td>
</tr>
<tr>
<td>Male Genital Symptoms:
☐ Erectile disorder
☐ Penile discharge
☐ Terminal drippling
☐ Testicular lump
☐ Urinary hesitancy
☐ Small urine stream
☐ Private area numbness</td>
<td>Breast:
☐ Discharge
☐ Lump</td>
<td>Psych:
☐ Anxiety
☐ Depression</td>
</tr>
<tr>
<td>☐ Private area pain</td>
<td rowspan="3">Neuro:
☐ Headache
☐ Dizziness
☐ Fainting
☐ Memory Loss
☐ Numbness / Tingling
☐ Claustrophobia
☐ Sleep disturbances
☐ Low back pain
☐ Sacral pain
☐ Difficulty walking
☐ Difficulty sitting
☐ Paralysis</td>
<td>Hematologic /Lymph:
☐ Anemia
☐ Excessive bleeding during surgery
☐ Easy bruising
☐ Swollen glands in the neck</td>
</tr>
<tr>
<td>Musculoskeletal:
☐ Joint pain
☐ Joint swelling
☐ Muscle aches
☐ Muscle weakness</td>
<td>Immune System:
☐ Auto-immune disease
☐ Seasonal allergies
☐ Allergic reaction to medication(s)
☐ Recurrent infections</td>
</tr>
<tr>
<td>Integument:
☐ Skin rash / Lesions</td>
<td></td>
</tr>
<tr>
<td colspan="3">☐ REVIEW OF SYSTEMS NEGATIVE</td>
</tr>
</table>

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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**

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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