Washington University in St. Louis Physicians

# *Welcome!*

## Neurosurgery Department at Washington University
## Cranial Health History Form

**To help us treat you, please fill this form out completely.**

Your Name _____ Today's Date ___/___/___

Your Age _____ Date of Birth ___/___/___

Are you (please √ one): ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

## PHYSICIANS

**Who referred you to us**

Name of Doctor _____

Fax Number _____

**Primary Care Physician**

If same as referring, check here: ☐

Name of Doctor _____

Fax Number _____

**List any other physicians you would like us to send our notes to:**

Name of Doctor _____

Fax Number _____

Name of Doctor _____

Fax Number _____

Name of Doctor _____

Fax Number _____

## WHAT PROBLEM ARE WE SEEING YOU FOR TODAY?

_____

_____

_____

_____



## PAST MEDICAL HISTORY

**Neurological Problems** If none, check here: ☐

| | | |
|---|---|---|
| TIA (Transient ischemic attack) | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No |
| Brain bleed (intracerebral hemorrhage) | ☐ Yes | ☐ No |
| Brain aneurysm | ☐ Yes | ☐ No |
| Brain vascular malformation (AVM, cavernous malformation) | ☐ Yes | ☐ No |
| Brain tumor (brain neoplasm) | ☐ Yes | ☐ No |
| Narrowing of carotid arteries (carotid artery stenosis) | ☐ Yes | ☐ No |
| Seizures (convulsions) | ☐ Yes | ☐ No |
| Dementia/Alzheimer's Disease | ☐ Yes | ☐ No |
| Cervical disc disease | ☐ Yes | ☐ No |
| Cervical stenosis | ☐ Yes | ☐ No |
| Lumbar disc disease | ☐ Yes | ☐ No |
| Lumbar stenosis | ☐ Yes | ☐ No |

**Heart problems** If none, check here: ☐

| | | |
|---|---|---|
| Chest pain (angina, coronary artery disease) | ☐ Yes | ☐ No |
| Heart Attack (myocardial infarction) | ☐ Yes | ☐ No |
| Congestive Heart Failure | ☐ Yes | ☐ No |
| High blood pressure (hypertension) | ☐ Yes | ☐ No |
| Aortic insufficiency | ☐ Yes | ☐ No |
| Mitral valve regurgitation | ☐ Yes | ☐ No |
| Atrial fibrillation | ☐ Yes | ☐ No |
| Mitral valve prolapse | ☐ Yes | ☐ No |

**Lung problems** If none, check here: ☐

| | | |
|---|---|---|
| Emphysema (COPD) | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No |
| Tuberculosis | ☐ Yes | ☐ No |

**Endocrine problems** If none, check here: ☐

| | | |
|---|---|---|
| High thyroid levels (hyperthyroidism) | ☐ Yes | ☐ No |
| Low thyroid levels (hypothyroidism) | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No |

## PAST MEDICAL HISTORY continued

**GI problems (stomach, colon)** If none, check here: ☐
Ulcers (peptic ulcer disease) ☐ Yes ☐ No
Reflux (gastroesophageal reflux disease) ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Liver failure ☐ Yes ☐ No
Diverticulosis ☐ Yes ☐ No

**Kidney/Bladder/ Prostate problems** If none, check here: ☐
Urinary infections (urinary tract infections) ☐ Yes ☐ No
Kidney infections (pyelonephritis) ☐ Yes ☐ No
Kidney dysfunction – no dialysis (renal insufficiency) ☐ Yes ☐ No
Kidney dysfunction – dialysis (renal failure) ☐ Yes ☐ No
Polycystic kidney disease ☐ Yes ☐ No
Prostate enlargement (benign prostatic hypertrophy) ☐ Yes ☐ No

**Blood problems** If none, check here: ☐
Bleeding disorder ☐ Yes ☐ No
Deep vein thrombosis ☐ Yes ☐ No
Pulmonary Embolus ☐ Yes ☐ No
Taking blood thinner (coumadin, warfarin, aspirin, etc.) ☐ Yes ☐ No

**Immune problems** If none, check here: ☐
HIV ☐ Yes ☐ No
AIDS ☐ Yes ☐ No

**Psychiatric Problems** If none, check here: ☐
Depression ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Bipolar disorder ☐ Yes ☐ No
Psychosis ☐ Yes ☐ No

**Cancer** If none, check here: ☐
Lung ☐ Yes ☐ No
Thyroid ☐ Yes ☐ No
Breast ☐ Yes ☐ No
Colon ☐ Yes ☐ No
Pancreas ☐ Yes ☐ No
Prostate ☐ Yes ☐ No
Kidney ☐ Yes ☐ No
Melanoma ☐ Yes ☐ No

**Other Problems** If none, check here: ☐
Rheumatoid Arthritis ☐ Yes ☐ No
Marfan's disease ☐ Yes ☐ No
Polyarteritis Nodosa ☐ Yes ☐ No
**Previous history of radiation** ☐ Yes ☐ No
What part of body _____
**Previous history of chemotherapy** ☐ Yes ☐ No
What type _____
**Women of childbearing age**
Possible pregnancy ☐ Yes ☐ No

**Please list other active medical problems not noted above** (These are problems for which you are currently taking medication or are seeing another physician):

_____

_____

## PAST SURGICAL HISTORY

If none, check here: ☐

| Surgery | | | Year(s) |
|---|---|---|---|
| Brain surgery (craniotomy) | ☐ Yes | ☐ No | _____ |
| Shunt | ☐ Yes | ☐ No | _____ |
| Spinal surgery – neck (cervical) | ☐ Yes | ☐ No | _____ |
| Spinal surgery – low back (lumbar) | ☐ Yes | ☐ No | _____ |
| Cataract surgery ☐ left ☐ right | ☐ Yes | ☐ No | _____ |

| Surgery | | | Year(s) |
|---|---|---|---|
| Heart bypass (CABG) | ☐ Yes | ☐ No | _____ |
| Heart valve replacement | ☐ Yes | ☐ No | _____ |
| Heart stent (angioplasty and stent) | ☐ Yes | ☐ No | _____ |
| Appendectomy | ☐ Yes | ☐ No | _____ |
| Cholecystectomy | ☐ Yes | ☐ No | _____ |
| Tonsillectomy | ☐ Yes | ☐ No | _____ |

## PAST SURGICAL HISTORY continued

**Please list other surgeries:**

| Type of/Reason For Surgery | Year | Type of/Reason For Surgery | Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## MEDICATIONS

**Please list all medications you are taking, including over-the-counter medications such as aspirin/ibuprofen and herbal medications.**

| Name of Medication | Dose/Frequency | Name of Medication | Dose/Frequency |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## ALLERGIES

**Please list all medication and non-medication allergies.** If none, check here: ☐

| | | | |
|---|---|---|---|
| | | | |
| | | | |

Do you have an allergy to latex? ☐ Yes ☐ No ☐ Unknown

## FAMILY HISTORY

**Please indicate any major medical problems in your family.** If none, check here: ☐

Brain aneurysm ☐ Yes ☐ No
☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister ☐ brother ☐ child

Cavernous malformation ☐ Yes ☐ No
☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister ☐ brother ☐ child

Hereditary Hemorrhagic Telangiectasia ☐ Yes ☐ No
☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister ☐ brother ☐ child

Neurofibromatosis ☐ Yes ☐ No ☐ Type I ☐ Type II
☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister ☐ brother ☐ child

Von Hippel-Lindau disease ☐ Yes ☐ No
☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister ☐ brother ☐ child

Brain tumor ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Hypertension ☐ Yes ☐ No

Heart disease/heart attack ☐ Yes ☐ No

## FAMILY HISTORY continued

**Other family medical history**

_____

_____

_____

## PERSONAL/SOCIAL HISTORY

**Your Height:** _____ feet _____ inches **Weight:** _____ pounds

**Do you drink alcohol?** ☐ No, never drank ☐ No, but did in the past Year Quit _____
☐ Yes (Check all that apply) ☐ Beer ☐ Wine ☐ Mixed Drinks ☐ Straight Liquor/Shots
How many drinks do you have in the average week? _____

**Do you use tobacco?** ☐ No, never ☐ No, but did in the past Year Quit _____
☐ Yes (Check all that apply) ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Pipe
How many cigarettes / cigars per day? _____

**Have you ever used illegal drugs?** ☐ No ☐ Yes (Check all that apply)
☐ Cocaine ☐ Marijuana ☐ Other _____

**Marital Status**

☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

**Work Status**

☐ Currently employed
Occupation _____
☐ Not currently employed
☐ Retired
☐ On disability
When disabled? _____
Reason for disability? _____

## REVIEW OF SYSTEMS Have you recently had any of the following symptoms?

| | | | | | |
|---|---|---|---|---|---|
| ☐ Yes | ☐ No | Tiredness/fatigue | ☐ Yes | ☐ No | Cough |
| ☐ Yes | ☐ No | Fevers | ☐ Yes | ☐ No | Heartburn (acid reflux) |
| ☐ Yes | ☐ No | Chills | ☐ Yes | ☐ No | Nausea |
| ☐ Yes | ☐ No | Sweat heavily at night (night sweats) | ☐ Yes | ☐ No | Vomiting |
| ☐ Yes | ☐ No | Recent weight loss (unintentional) | ☐ Yes | ☐ No | Easy bleeding |
| ☐ Yes | ☐ No | Headache | ☐ Yes | ☐ No | Easy bruising |
| ☐ Yes | ☐ No | Chest pain | ☐ Yes | ☐ No | Diffuse joint pains (arthralgia) |
| ☐ Yes | ☐ No | Palpitations (heart racing) | ☐ Yes | ☐ No | Muscle aches |
| ☐ Yes | ☐ No | Shortness of breath | ☐ Yes | ☐ No | Anxiety |
| ☐ Yes | ☐ No | Difficulty breathing during physical activity | ☐ Yes | ☐ No | Depression |

## PLEASE ANSWER YES OR NO TO THE FOLLOWING:

| | | |
|---|---|---|
| Is this a workman's compensation case? | ☐ Yes | ☐ No |
| Is this related to an injury or car accident? | ☐ Yes | ☐ No |
| Are you currently involved in any litigation or lawsuits? | ☐ Yes | ☐ No |
| Have you consulted a lawyer about your injury/problem? | ☐ Yes | ☐ No |