Senta Clinic, Division of Neurological Surgery
Confidential Medical History

The following is required for your electronic file. If you are unsure of an answer, insert a "?" in the space.

Patient Name: _____

What are you seeing us for? _____

General Health

Do you smoke? Y N # Packs/day? _____ For how long? _____ Year quit: _____

Alcoholic beverages/day: _____

If you have medication allergies, to what? _____

What type of reaction do you have to them? _____

Past Medical History

Do you/have you ever had any major illnesses? (Diabetes, heart disease, kidney disease, stroke, etc)

_____

Surgical History

Operation	Year
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you/have you ever had:

Abnormal bleeding or anemia	Y	N	Difficulty climbing stairs	Y	N
Ulcer or gastritis	Y	N	Difficulty swallowing	Y	N
Weight loss	Y	N	Shortness of breath	Y	N
Fits/Convulsions/Seizures	Y	N	Numbness	Y	N
Double vision	Y	N	Paralysis	Y	N
Sudden vision loss	Y	N	Diabetes	Y	N
Decreased hearing	Y	N	Stroke	Y	N
Memory loss	Y	N	Heart surgery	Y	N
Mental illness	Y	N	Chest pain	Y	N
Alcohol/Drug addiction	Y	N	Hypertension	Y	N

Patient Signature: _____ Date: _____