UCLA Health

NEUROSURGERY PATIENT QUESTIONNAIRE
HISTORY AND PHYSICAL NEUROSCIENCES
DEPARTMENT OF NEUROSURGERY

MRN:
Patient Name:

(Patient Label)

Chief Complaint

Reason for today's visit: _____

_____

Allergies / Contraindications

Have you ever had and allergic reaction to any medication? If yes, please list medication and reaction: _____

_____

Medications

Please list any medications (prescription and over the counter) you are currently taking (including vitamins and aspirin):

Name	Dosage	Frequency Per Day

Preferred Pharmacy: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: _____ Fax Number: _____

Preferred Laboratory: ☐ UCLA ☐ Outside: _____

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Medical History

Have you ever been diagnosed with any of the following conditions?

Brain Tumor	☐ Yes	☐ No		Lung Disease	☐ Yes ☐ No
Cancer	☐ Yes	☐ No		Memory Loss	☐ Yes ☐ No
Chronic Pain	☐ Yes	☐ No		Migraines	☐ Yes ☐ No
Confusion	☐ Yes	☐ No		Movement Disorder	☐ Yes ☐ No
Convulsions	☐ Yes	☐ No		Multiple Sclerosis	☐ Yes ☐ No
Coronary Artery Disease	☐ Yes	☐ No		Neurocutaneous Disorder	☐ Yes ☐ No
Depression	☐ Yes	☐ No		Neuropathy	☐ Yes ☐ No
Diabetes	☐ Yes	☐ No		Parkinson's Disease	☐ Yes ☐ No
Head Injury	☐ Yes	☐ No		Seizure	☐ Yes ☐ No
Headaches	☐ Yes	☐ No		Stroke	☐ Yes ☐ No
Hearing Loss	☐ Yes	☐ No		Syncope	☐ Yes ☐ No
Heart Disease	☐ Yes	☐ No		Thyroid Disease	☐ Yes ☐ No
Heart Palpitations	☐ Yes	☐ No		Toxic Exposure	☐ Yes ☐ No
Hypertension	☐ Yes	☐ No		Tremor	☐ Yes ☐ No
Kidney Disease	☐ Yes	☐ No		Vascular Disorder	☐ Yes ☐ No
Liver Disease	☐ Yes	☐ No		Vision Problems	☐ Yes ☐ No

Other Medical Problems: (Please list all medical conditions not listed above):

_____

_____

_____

_____

Surgical History

Please list all previous operations/hospitalizations:

Type of Operation	Year	Complications

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Family History

For example: Cancer, Depression, Diabetes, Epilepsy, Heart Disease, Hypertension, Memory Loss, Multiple Sclerosis, Muscle Weakness, Psychosis, Seizures, Stroke, Thyroid Disease, etc…

Family Member	Age (or age at death)	Living Yes	Living No	Medical Problems
Mother		☐	☐	
Father		☐	☐	
Sister		☐	☐	
Brother		☐	☐	
Maternal Aunt		☐	☐	
Maternal Uncle		☐	☐	
Paternal Aunt		☐	☐	
Paternal Uncle		☐	☐	
Maternal Grandmother		☐	☐	
Maternal Grandfather		☐	☐	
Paternal Grandmother		☐	☐	
Paternal Grandfather		☐	☐	
Child		☐	☐	
Child		☐	☐	
Child		☐	☐	

Other: _____

☐ Adopted ☐ Family History Unknown

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Social History

Tobacco Use: ☐ Yes ☐ No Stop Date: _____

Packs/Day ☐ ¼ Pack ☐ ½ Pack ☐ 1 Pack ☐ > 1 Pack

Years: ☐ < 1yr ☐ 1 – 5 yrs ☐ > 5 yrs ☐ years _____

Smokeless Tobacco? ☐ Yes ☐ No Stop Date: _____

Ready to stop: ☐ Yes ☐ No Stop Date: _____

Alcohol Use: ☐ Yes ☐ No

Drinks/Week:

Type	Frequency per Week
Glasses of Wine (5 oz.)	
Cans of Beer (12 oz.)	
Shots of Liquor (1.5)	
Drinks containing 1.5 oz. of alcohol	

Drug Use: ☐ Yes ☐ No

Type	Frequency per Week

Have you had significant exposure to:

Pesticides? ☐ Yes ☐ No

Toxic Waste? ☐ Yes ☐ No

Handedness: ☐ Right ☐ Left

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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Mobility History

1. Do you need help to transfer to a chair? ☐ Yes ☐ No
2. Do you use any assistive devices (cane, walker, wheelchair)? ☐ Yes ☐ No
3. Can you walk in your home with or without assistance? ☐ Yes ☐ No
4. Can you walk outside your home with or without assistance? ☐ Yes ☐ No
5. Have you had any falls within the last 3 months? ☐ Yes ☐ No
6. Has your current physical state been stable for:
   - 0-3 months? ☐ Yes ☐ No
   - 4-6 months? ☐ Yes ☐ No
   - More than 6 months? ☐ Yes ☐ No

Pain History

1. Do you now, or have you in the past, take medication for anxiety? ☐ Yes ☐ No
2. Do you use marijuana? ☐ Yes ☐ No
3. Do you have a history of drug abuse/ dependence (prescription medications, cocaine, amphetamines, heroin)? (This information is confidential but is important for your care during surgery) ☐ Yes (Please list what drugs you use)
   ☐ No
4. Do you now, or have you in the past, take any pain medications (other than Tylenol or Advil) on a regular basis? ☐ Yes (Please list them)
   ☐ No
5. Do you now or have you in the past had a problem with chronic pain (pain lasting longer than 3 months for which you sought the help of a physician)? ☐ Yes ☐ No

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Review of Systems

Have you experienced any of the following symptoms?

System	Check Yes or No
Allergy / Immunology	
Low resistance to infection	☐ Yes ☐ No
Environmental allergies	☐ Yes ☐ No
Cardiovascular	
Chest pains or angina	☐ Yes ☐ No
Irregular heart rhythm	☐ Yes ☐ No
Swelling of the feet, ankles, and hands	☐ Yes ☐ No
Constitutional	
Good general health lately	☐ Yes ☐ No
Recent weight changes	☐ Yes ☐ No
Recurrent fevers, chills, sweats	☐ Yes ☐ No
Extreme fatigue	☐ Yes ☐ No
Frequent nausea, vomiting	☐ Yes ☐ No
Difficulty sleeping	☐ Yes ☐ No
Ears, Nose, Mouth, Throat	
Change in hearing	☐ Yes ☐ No
Ringing in the ears	☐ Yes ☐ No
Recent nose bleeds	☐ Yes ☐ No
Chronic sinus problems	☐ Yes ☐ No
Voice changes	☐ Yes ☐ No
Eyes	
Wear glasses and/or contact lenses	☐ Yes ☐ No
Change in vision	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No
Endocrine	
Heat or cold intolerance	☐ Yes ☐ No
Excess thirst or urination	☐ Yes ☐ No
Gastrointestinal	
Change in appetite	☐ Yes ☐ No
Severe heart burn	☐ Yes ☐ No
Vomiting blood	☐ Yes ☐ No
Frequent diarrhea	☐ Yes ☐ No
Constipation	☐ Yes ☐ No
Black or bloody stools	☐ Yes ☐ No
Abdominal pain	☐ Yes ☐ No

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System	Check Yes or No
Genitourinary	
Blood in urine	☐ Yes ☐ No
Burning with Urination	☐ Yes ☐ No
Difficult/frequent urination	☐ Yes ☐ No
Lack of bladder control	☐ Yes ☐ No
Sexually transmitted disease	☐ Yes ☐ No
Change in sexual function	☐ Yes ☐ No
Hematologic/Lymphatic	
Easy bruising	☐ Yes ☐ No
Frequent bleeding	☐ Yes ☐ No
Enlarged lymph nodes	☐ Yes ☐ No
Integumentary Skin & Breasts	
Unusual or prolonged rashes	☐ Yes ☐ No
Breast pain or lump	☐ Yes ☐ No
Change in hair or nails	☐ Yes ☐ No
Musculoskeletal	
Joint/muscle stiffness or pain	☐ Yes ☐ No
Weakness of muscles or joints	☐ Yes ☐ No
Back pain	☐ Yes ☐ No
Difficulty walking	☐ Yes ☐ No
Neurological	
Headaches	☐ Yes ☐ No
Numbness/tingling sensation	☐ Yes ☐ No
Weakness or paralysis	☐ Yes ☐ No
Convulsions or seizures	☐ Yes ☐ No
Change in memory/concentration	☐ Yes ☐ No
Loss or blurring of vision or double vision	☐ Yes ☐ No
Blackouts/dizziness	☐ Yes ☐ No
Memory loss or confusion	☐ Yes ☐ No
Other neurological problems	☐ Yes ☐ No
Psychiatric	
Nervousness	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Other	☐ Yes ☐ No
Respiratory	
Breathing/problems/shortness of breath	☐ Yes ☐ No
Coughing up blood	☐ Yes ☐ No
Chronic cough	☐ Yes ☐ No

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Referral Contact

Were you by referred by another physician?
Please fill out address completely. This is important to ensure proper communication with your physician.

Referring MD: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

If you have a primary care physician other than your referring physician, please complete the information below.

Primary Care MD: _____

Street Address: _____

City: _____ State:_____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Would you like the information from today's visit sent to a physician other than those listed above?

Name of MD: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

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Current Occupation: _____

Employer _____ How long? _____

Are you presently: ☐ Working ☐ Disabled ☐ Retired _____

Is the chief complaint a result of a specific injury or accident? ☐ Yes ☐ No

Date of accident _____ Type of accident _____

Are you involved in litigation regarding this condition? ☐ Yes ☐ No

The above information is accurate to the best of my knowledge:

Patient or Representative Signature _____ Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____ ID # _____ Date _____ Time _____

Physician Signature _____ ID # _____ Date _____ Time _____