

MRN:
Patient Name:
(Patient Label)

**NEUROSURGERY PATIENT QUESTIONNAIRE  
HISTORY AND PHYSICAL NEUROSCIENCES  
DEPARTMENT OF NEUROSURGERY**

**Chief Complaint**

Reason for today's visit: \_\_\_\_\_

**Allergies / Contraindications**

Have you ever had an 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Memory Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Movement Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary Artery Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurocutaneous Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neuropathy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Syncope	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Toxic Exposure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tremor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vascular Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

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**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		Medical Problems
		Yes	No	
Mother		<input type="checkbox"/>	<input type="checkbox"/>	
Father		<input type="checkbox"/>	<input type="checkbox"/>	
Sister		<input type="checkbox"/>	<input type="checkbox"/>	
Brother		<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Aunt		<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Uncle		<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Aunt		<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Uncle		<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Grandmother		<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Grandfather		<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Grandmother		<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Grandfather		<input type="checkbox"/>	<input type="checkbox"/>	
Child		<input type="checkbox"/>	<input type="checkbox"/>	
Child		<input type="checkbox"/>	<input type="checkbox"/>	
Child		<input type="checkbox"/>	<input type="checkbox"/>	

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?

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

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



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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 \_\_\_\_\_