NEW HAMPSHIRE NEUROSPINE INSTITUTE

INITIAL CRANIAL EVALUATION

Today's Date: Medical Records #:
Last Name: First Name:
Date of Birth: Age: Male Female
Height: ______ in. Weight: _______ lbs.
Primary Care Physician (PCP): Physician Specialists: ______________________________
Referred by:

History:

Date when symptoms began: ______ / ______ / ______

Briefly describe your symptoms: ____

____

Do you experience headaches? Yes ☐ No ☐

If yes, frequency. Daily ☐ Weekly ☐ Monthly ☐ Other: ______________________________

Do you have any nausea and/or vomiting? Yes ☐ No ☐

Any visual abnormalities? Yes ☐ No ☐

If yes, double vision? Yes ☐ No ☐ Blurred vision? Yes ☐ No ☐

Loss of vision? Yes ☐ No ☐

Any hearing loss? Yes ☐ No ☐ If yes: Right ☐ Left ☐

Any dizziness? Yes ☐ No ☐

Any facial numbness? Yes ☐ No ☐ Extremity numbness? Yes ☐ No ☐

Difficulty with memory? Yes ☐ No ☐

Any weakness? Yes ☐ No ☐ Arms: Yes ☐ Legs: Yes ☐

Any trouble with balance? Yes ☐ No ☐

Any seizures? Yes ☐ No ☐

Any history of stroke? Yes ☐ No ☐

Any family history of intracranial aneurysms? Yes ☐ No ☐

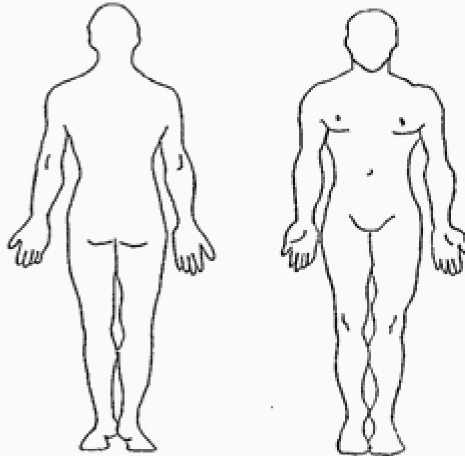
Have you been started on steroids? Yes ☐ No ☐

Seizure medications? Yes ☐ No ☐ If so, which one? ____

What diagnostic tests related to your head/brain have you had: (fill in approximate dates {month/year})

MRI ☐ ____ / ____ / ____ CT Scan ☐ ____ / ____ / ____ EEG ☐ ____ / ____ / ____

SHOW US WHERE YOUR PAIN IS LOCATED
Mark these drawings according to where you hurt
P = PAIN
N = NUMBNESS (Numbness is the loss of sensation or the feeling of being "asleep" - it is not painful.)



Medical History: (check all that apply) Do you have or have you had any of the following?

No medical conditions ☐

Diabetes ☐ Heart Disease ☐ Stroke ☐ Asthma ☐ Depression ☐ Hepatitis ☐ High Blood Pressure ☐

Lung Disease ☐ Alcohol Abuse ☐ Ulcer Disease ☐ Vascular Disease ☐ Thyroid Disease ☐ Osteoporosis ☐

Tuberculosis ☐ Arthritis ☐ High Cholesterol ☐ Anxiety ☐ ADD/ADHD ☐ GERD ☐

Cancer ☐ (type: ________________________________) Other: ______________________________________

Have you had any previous surgery: (add dates) None ☐

Tonsils ☐ ______________ Appendectomy ☐ ______________ Gallbladder ☐ ______________

Hysterectomy ☐ ______________ Heart ☐ ______________ Blood vessels ☐ ______________

Lung ☐ ______________ Kidney ☐ ______________ Stomach or intestinal ☐ ______________

Other(s): ☐ ______________ ______________ ______________ ______________

List all of your current medications (Please include dosage and frequency): No medications ☐

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Pharmacy: ________________________________ Location: ______________

Do you have any drug allergies: None ☐

If yes please list and describe what happens. ________________________________

Social History:

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Do you have any children: No ☐ Yes ☐ (number: ______)

Living situation: Live with spouse ☐ Live with significant other ☐ Live alone ☐ Nursing home ☐

Live with parents ☐ Live with adult children ☐ Live with minor children ☐

Smoking: Never smoked ☐ Quit ______ months ago ☐ Quit ______ years ago ☐ Yes ☐ ______ pks per day x ______ yrs.

Do you drink alcohol: No ☐ Yes ☐ If yes, how much alcohol do you drink each day: ______ drinks/day.

Have you had any weight changes in the past year: No ☐ Yes, gained ______ lbs. ☐ Yes, lost ______ lbs. ☐

What is the last grade you completed:

______ Grade ☐ GED ☐ High School Graduate ☐ 2-yr Associates Degree ☐ Technical School ☐

______ yrs. College ☐ Bachelors Degree ☐ Post Graduate or Professional Degree ☐

What is your race?: American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐

Native Hawaiian or other Pacific Island ☐ Unknown\Decline to answer ☐

What is your ethnicity?: Arab-American ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown\Decline to answer ☐

What is your language preference?: ______________________________

Family History:

Do any of these diseases run in your immediate family (parents, brothers, sisters only):

No medical conditions ☐

Diabetes ☐ Heart Disease ☐ Stroke ☐ Asthma ☐ Depression ☐ Hepatitis B ☐ High Blood Pressure ☐

Lung Disease ☐ Alcohol Abuse ☐ Ulcer Disease ☐ Vascular Disease ☐ Thyroid Disease ☐ Arthritis ☐

Cancer ☐ (type: ________________________________) Other: ____

Work History:

Present employer: ____

Primary occupation: ____

How long have you worked at your current job: __________ months __________ years

Current work situation:

Working ☐ Paid leave ☐ Unpaid leave ☐ Unemployed ☐ Homemaker ☐ Student ☐

Permanently disability / retired due to head/brain ☐ Permanently disability / retired for other health reasons ☐

Retired not due to health ☐

Exercise Habits:

Do you routinely exercise? If so, how often?:

____

____

____

Current Functional Status:

Which of these functions are you presently able to perform:

Personal hygiene ☐ Cooking ☐ Light house cleaning (sweeping/dusting) ☐ Laundry ☐

Heavy housework (vacuuming) ☐ Yardwork ☐ Driving ____ min. ☐ Sitting ____ min. ☐

Walking ____ min. ☐ Standing ____ min. ☐ Lifting ____ lbs. ☐

Review of Systems: *Please check any condition you have experienced within the past year:*

Recent nausea or vomiting	☐	Loss of hearing	☐	Frequent headaches	☐	Incontinence of bowel	☐
Hot or cold spells	☐	Nosebleeds	☐	Blackouts	☐	Incontinence of bladder	☐
Swollen ankles	☐	Stomach pain	☐	Seizures	☐		
Difficulty swallowing	☐	Ulcers	☐	Recent weight change	☐		
Morning cough	☐	Fever or chills	☐	Nervous exhaustion	☐		
Shortness of breath	☐	Constipation	☐	Claustrophobia	☐		
Heart or chest pain	☐	Poor appetite	☐	Pacemaker	☐		
Abnormal heartbeat	☐	Burning urination	☐	Metal in eye	☐	R or L	
Calf cramps w/ walking	☐	Recent diarrhea	☐				

If you checked any of the above, have you discussed the problem(s) with your primary doctor? Yes ☐ No ☐

MD USE ONLY

RX:

Vital signs:

MD Notes:
Who is accompanying a minor?