Neurosurgical Associates, Cassidy & Guerin, M.D., P.A.

Name: ______________________________________ Date of Visit: ____________________________

Date of Birth: ___________ Gender: ________ Age: _____ Dr. You are seeing:_______________

Family Physician: ___________________________ Referring Physician: _______________________

TO BE COMPLETED BY OFFICE

Height: _______ Weight: _______ B/P: __________ Pulse: _________

MEDICAL HISTORY

WHAT MEDICAL PROBLEM BRINGS YOU HERE TODAY? ______________________________

ALLERGIES

Yes: ____ No: _____

Latex Allergy: ______

List all allergies below:

____

____

____

____

____

____

ALL CURRENT MEDICATIONS

List drug names, dose, number of times per day

____

____

____

____

____

____

Do you take Aspirin? _______ Do you drink alcohol? ____________ Smoker: Yes No Amt: _____

RECENT FLU / PNEUMONIA VACCINE: YES or NO DATE: ____________________

OPERATIONS (include yr)

____

____

____

____

____

____

MEDICAL ILLNESSES or HOSPITAL ADMISSIONS(incl yr)

____

____

____

____

____

____

PAST MEDICAL HISTORY:

Do you have or have you EVER had any of the following:

Self	
	Acid Reflux
	Anesthesia problem
	Angina
	Any breathing problem
	ANY Heart problem
	Arthritis
	Asthma
	Bleeding problem
	Bladder
	Blood clots
	Blood pressure
	Blood Transfusion
	Bowel
	Cancer
	Chest pain
	Claustrophobia
	COPD
	Diabetes
	Emphysema
	Hearing Loss
	Heart Fibrillation
	Hepatitis
	HIV or AIDS
	Kidney problems
	Pacemaker
	Psychiatry evaluation
	Recent fever
	Seizures
	Skin rash/Blisters
	Sleep Apnea
	Stroke
	Tumor
	Ulcers
	Visual problems
	Weight Change
	**Other Medical Conditions:

FAMILY MEDICAL HISTORY: ____