CONNECTICUT NEUROSURGICAL SPECIALISTS, P.C.

MEDICAL HISTORY

REFERRED BY: INTERNET ER MAGAZINE NEWSPAPER
PATIENT: ______________ HEALTHCARE PROFESSIONAL

REFERRING DOCTOR'S NAME,ADDRESS,PHONE #: ______________
PRIMARY CARE DOCTOR'S NAME,ADDRESS,PHONE #: ______________

LEFT OR RIGHT HANDED? __________
OCCUPATION/DUTIES: ______________

AREAS OF BODY INVOLVED & SIDE (Describe problem): ______________
____

DATE OF ONSET OR ACCIDENT: ______________
IF AN ACCIDENT OR INJURY, HOW DID IT OCCUR: ______________
____

LIST MEDICATIONS & DOSAGE YOU ARE TAKING: ______________
____

ARE YOU ALLERGIC TO ANY MEDICATIONS: ______ IF YES, WHICH ONE(S) AND DESCRIBE REACTION(S): ______________
____

ARE YOU ALLERGIC TO LATEX? ______________

LIST ANY CURRENT MEDICAL CONDITIONS (i.e. Diabetes, High Blood Pressure, Cancer, Heart): ______________

IS THERE A FAMILY HISTORY OF THIS TYPE OF PROBLEM? ______________
IF SO, PLEASE EXPLAIN: ______________
____

PREVIOUS OPERATIONS & DATES: ______________
____

PREVIOUS HOSPITALIZATIONS & DATES (Other than above): ______________
____

DO YOU SMOKE? __________ IF SO, HOW MUCH PER DAY? ______________

DO YOU DRINK ALCOHOLIC BEVERAGES? IF SO, HOW MUCH DAILY? __________

OTHER ISSUES YOU WANT US TO BE AWARE OF: ______________
____
____

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: ______________________ DATE: ______________