Jeff Pan, M.D. Neurosurgery
Patient Information Sheet

Name: ______________________________ Date: ______________________

Age: ______ Date of Birth: __________ Height: _________ Weight: ______________

Marital Status
- □ Married
- □ Divorced
- □ Separated
- □ Widowed
- □ Single

Work Status:
- □ Employed as __________
- □ Worker's Comp
- □ Retired
- □ Disabled
- □ Unemployed

General Health Status:
- □ Excellent
- □ Good
- □ Fair
- □ Poor

Are you:
- □ Right Handed
- □ Left Handed

Please list all the physicians you are currently seeing and/or whom you want to be informed about your progress:

Physician who referred you:

Name: ______________________________

Address: ______________________________

____

Telephone: (   ) ______________________________

Your Family Physician:

Name: ______________________________

Address: ______________________________

____

Telephone: (   ) ______________________________

Other Physician:

Name: ______________________________

Address: ______________________________

____

Telephone: (   ) ______________________________

1. Please describe the type of medical problem or symptoms that you are being seen for today:

____

____

2. Are you currently involved in litigation or plan to be involved? ______________________

3. Were you injured at work? Were you injured in a motor vehicle accident? If yes, please explain:

____

____

Date of injury? ______________ Date that you last worked? ______________

4. Do you now have or have you ever had the following:

1. Heart problems	□ Yes □ No	6.GI problems ulcer, hiatal hernia, gastritis	□ Yes □ No
2. Lung problems	□ Yes □ No	7. Liver disease (hepatitis)	□ Yes □ No
3. Kidney problems	□ Yes □ No	8. Problems with blood (blood clotting)	□ Yes □ No
4. High blood pressure	□ Yes □ No	9. Any type of cancer	□ Yes □ No
5. Diabetes	□ Yes □ No	10. Other	□ Yes □ No

5. Please list all surgeries you have had including the year they were performed: ______________________________

____

____

6. Have you ever had radiation therapy? □ Yes □ No
Have you ever had chemotherapy? □ Yes □ No
Please list the date(s) and the facility where you were treated: ______________________________

7. Please list any medications that you are currently taking. List the name of the medication, the frequency and the dosage:

____

____

8. Are you allergic to any medications? Please list the name of the medication and the reactions caused by taking the medication:

____

____

9. Have you ever had a reaction to any dye given for a special test? If so, what was the test and what kind of reaction did you have?

____

____

10. Are you aware of an allergy to Latex or Iodine-based soap? ______________________________

11. Do you use:

A. Tobacco	□ Yes □ No	How much per day? ______________________________
B. Alcohol	□ Yes □ No	How much per day? ______________________________
C. Drugs	□ Yes □ No	How much per day? ______________________________

12. Are you on a special diet? If so, please specify the type of diet. ______________________________

____

13. How many hours of sleep per night do you get on average? ______________ hours

14. Is there other information about yourself that you would like for us to know? ______________________________

____

15. Has anyone in your immediate family had:

A. High blood pressure	□ Yes	□ No	If so who? ______________________________
B. Heart Disease	□ Yes	□ No	If so who? ______________________________
C. Cancer	□ Yes	□ No	If so who? ______________________________
D. Diabetes	□ Yes	□ No	If so who? ______________________________
E. Asthma	□ Yes	□ No	If so who? ______________________________
F. Stroke	□ Yes	□ No	If so who? ______________________________
G. Seizures	□ Yes	□ No	If so who? ______________________________
H. Migraine	□ Yes	□ No	If so who? ______________________________
I. Other			______________________________

16. Please provide the following information:

Mother: (if living):
Age: ________________________
Health status: _________________

(if deceased):
At what age: _______________________
Cause of death: __________________________

Father: (if living):
Age: ________________________
Health status: _________________

(if deceased):
Age: _______________________
Cause of death: __________________________

17. Do you have any living sibling? If so, how many?

18. If you have deceased siblings:

Sex	Age at death	Cause of death
_______	__________	____________

19. Do you have any living children? Yes No

If so, how many? ______________

20. If you have deceased children.

Sex	Age at death	Cause of death
________	_________________	____
________	_________________	____

20. REVIEW OF SYSTEMS: Are you **currently** experiencing any of the following symptoms? Please check yes or no. If you are not sure, please leave it blank.

NO	**Yes**	**GENERAL**
□	□	WEAKNESS
□	□	TIREDNESS
□	□	LACK OF APPETITE
□	□	EXCESS APPETITE
□	□	WEIGHT LOSS
□	□	WEIGT GAIN
□	□	CHILLS
□	□	FEVER
□	□	NIGHT SWEATS
□	□	DIFFICULTY SLEEPING

NO	**YES**	**EYES, EARS, NOSE, THROAT**
□	□	DECREASED ABILITY TO SEE
□	□	BLURRED VISION
□	□	SPOTS BEFORE YOUR EYES
□	□	PAIN IN THE EYES
□	□	DIFFICULTY IN HEARING
□	□	RINGING IN YOUR EARS
□	□	DISCHARGE FROM THE EARS
□	□	FREQUENT NASAL DISCHARGE
□	□	HOARSENESS

NO	**YES**	**RESPIRATORY**
□	□	COUGH
□	□	WHEEZING
□	□	ASTHMA
□	□	SHORTNESS OF BREATH AT REST
□	□	SHORTNESS OF BREATH WITH EXTERTION

NO	YES	CARDIOVASCULAR
□	□	CHEST PAIN, TIGHTNESS OR SQUEEZING
□	□	SHORTNESS OF BREATH LYING DOWN
□	□	NEED TO SIT UP TO BREATHE
□	□	HEART RACING
□	□	IRREGULAR HEART BEAT (PALPITATIONS)
□	□	HEART MUMUR
□	□	SWELLING OF THE LEGS
□	□	VARICOSE VEINS
□	□	LEG PAIN AT REST
□	□	LEG PAIN WITH EXERTION
□	□	BLUE/PURPLE DISCOLORATION OF HAND/FEET

NO	YES	GASTROINTESTINAL
□	□	NAUSEA
□	□	VOMITING
□	□	DIARRHEA
□	□	CONSTIPATION
□	□	HEARTBURN
□	□	ABDOMINAL PAIN
□	□	BRIGHT RED BLOOD IN STOOLS
□	□	BLACK STOOLS
□	□	CHANGE IN BOWEL HABITS
□	□	NEED FOR ANTACIDS

NO	YES	URINARY
□	□	URINARY TRACT INFECTIONS
□	□	PAIN OR BURNING ON URINATION
□	□	FREQUENT URINATION-DAY
□	□	FREQUENT URINATION-NIGHT
□	□	UNUSUALLY LARGE VOLUMES OF URINE
□	□	EXTREME URGES TO URINATE
□	□	DIFFICULTY STARTING URINARY STREAM
□	□	DIFFICULTY STOPPING URINARY STREAM
□	□	KIDNEY STONES

NO	YES	GENITO-REPRODUCTIVE (MALE)
□	□	HISTORY OF SEXUALLY TRANSMITTED DISEASE
□	□	DISCHARGE FROM PENIS
□	□	TESTICULAR PAIN
□	□	LUMPS IN TESTICLES OR SCROTUM
□	□	DECREASED SEXUAL DESIRE
□	□	DECREASED ABILITY TO ACHIEVE ERECTION

NO	YES	GENITO-REPRODUCTIVE (FEMALE)
________		AGE OF ONSET OF MENSTRUAL PERIODS
________		AGE WHICH PERIODS STOPPED (MENOPAUSE)
________		HOW **FAR APART** ARE YOUR PERIODS?
________		HOW MANY DAYS DO THEY LAST?
		IS FLOW, SCANTY OR NORMAL? (CIRCLE ONE)
□	□	DO YOU EVER BLEED BETWEEN PERIODS?
________		WHEN WAS DATE OF YOUR LAST NORMAL PERIOD?
________		WHEN WAS DATE OF THE LAST PERIOD BEFORE THAT?
□	□	HAVE YOU HAD ANY SEXUALLY TRANSMITTED DISEASE?
□	□	DO YOU HAVE DECREASED SEXUAL DRIVE?
□	□	HAVE YOU HAD ANY VAGINAL BLEEDING SINCE MENOPAUSE?
□	□	ARE YOU BOTHERED BY HOT FLASHES?
□	□	ARE YOU TAKING ANY FEMALE HORMONES?

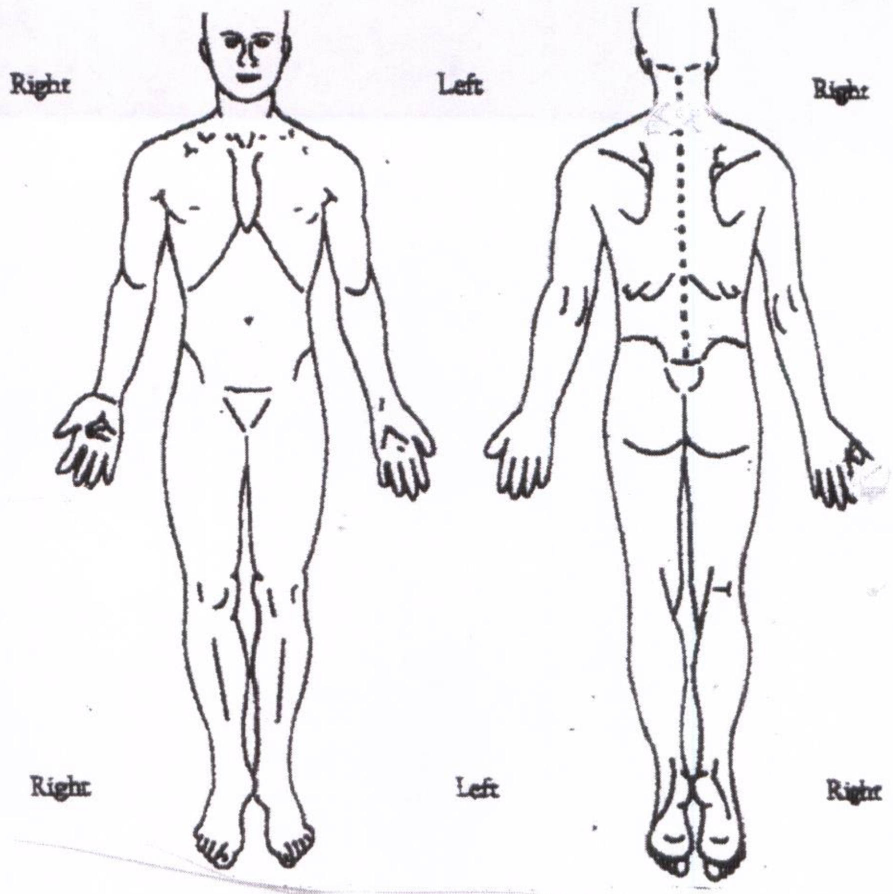
NO	YES	**MUSCULOSKELETAL**
□	□	MUSCLE PAIN
□	□	NECK PAIN
□	□	SHOULDER OR ARM PAIN
□	□	BACK PAIN
□	□	PAIN DOWN YOUR LEGS
		□ RIGHT SIDE □ LEFT SIDE
□	□	PAINFUL JOINTS
□	□	SWELLING OF ANY JOINTS
□	□	REDNESS OF ANY JOINTS
□	□	STIFFNESS OF ANY JOINTS
□	□	DEFORMITIES OF THE JOINTS OR EXTREMITIES

NO	YES	**ENDOCRINE**
□	□	GOITER
□	□	HEAT INTOLERANCE
□	□	COLD INTOLERANCE
□	□	TREMULOUSNESS OF THE HANDS
□	□	CHANGE IN PITCH OF THE VOICE
□	□	INCREASED BODY HAIR (FACE, UNDER ARMS, PUBIC)
□	□	DECREASED BODY HAIR (FACE, UNDER ARMS, PUBIC)
□	□	DECREASE IN BREAST SIZE
□	□	LOSS OF PERIODS (DISREGARD IF FROM NORMAL MENOPAUSE)
□	□	INCREASED THIRST
□	□	INCREASED URINATION
□	□	MARKED INCREASE IN APPETITE
□	□	INCREASE IN BREAST SIZE

NO	YES	**NEUROLOGIC/PSYCHIATRIC**
□	□	SEIZURES
□	□	HEADACHE
□	□	BLACKOUTS
□	□	DIZZINESS
□	□	DOUBLE VISION
□	□	PARALYSIS OR WEAKNESS OF LIMB(S)
□	□	LOSS OF SENSATION
□	□	LOSS OF BALANCE
□	□	LOSS OF COORDINATION
□	□	DIFFICULTY IN SPEAKING
□	□	NERVOUSNESS
□	□	DEPRESSION
□	□	DIFFICULTY IN GOING TO SLEEP
□	□	EARLY MORNING AWAKENING
□	□	DIFFICULTY WITH MEMORY FOR PAST EVENTS
□	□	DIFFICULTY WITH MEMORY FOR RECENT EVENTS
□	□	DIFFICULTY WITH THINKING OR PROBLEM SOLVING

NO	YES	**SKIN**
□	□	DRYNESS OF SKIN
□	□	ITCHING
□	□	RASH
□	□	CHANGE IN SKIN COLOR
□	□	CHANGE IN TEXTURE OF HAIR
□	□	CHANGE IN SKIN TEMPERATURE
□	□	FALLING OUT OF THE HAIR
□	□	NAIL CHANGES
□	□	SKIN CANCER

Please complete the following:



Severity (if applicable)	Description
_______Constant	_______Aches
_______Occasional	_______Throbs
_______Wakes you up	_______Burns
_______Difficulty	_______Tingles
	_______Stabbing
	_______Numbness

Please indicate with an "X" or "O" on the above the location of your symptoms.

X= Pain
O= Numbness or tingling

Indicate current level of pain on the following scale:

No Pain — Intolerable

0 1 2 3 4 5 6 7 8 9 10

What makes your condition worse?______________________________

What helps your condition?______________________________

Other body parts affected:______________________________

Symptoms affected by:______________________________

What kind of effect do the following activities have on your symptoms?

	SITTING	STANDING	EXERCISE	REST
INCREASE				
DECREASE				