MARK BELZA, MD
NEUROSURGERY
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Name: _____ **Date:** _____ DOB: _____

CHECK IF YOU HAVE HISTORY OF:

_____Aneurysm
_____Anxiety
_____Arthritis
_____Asthma
_____Back Injury
_____Bleeding disorder
_____Brain Tumor
_____COPD
_____Cancer
_____CAD
_____Dementia
_____Depression
_____Diabetes
_____Encephalitis
_____Epilepsy/Seizures
_____Fibromyalgia
_____Head Trauma/Injury
_____Headache/Migraine
_____Heart Disease
_____Hepatitis
_____Hyperlipidemia
_____Hypertension
_____Hyperthyroidism
_____Kidney Disease
_____MRSA
_____Multiple Sclerosis
_____Neck Injury
_____Neurological problems
_____Osteoporosis
_____Stroke
_____Ulcers

FAMILY HISTORY:

Condition	Relationship
_____Diabetes	_____
_____Epilepsy	_____
_____Headache	_____
_____Heart disease	_____
_____Hypercholesterolemia	_____
_____Hypertension	_____
_____Malignant Neoplasm	_____
_____Migraine	_____
_____Seizure	_____

HEALTH HABITS:

Alcohol yes no how much_____
Caffeine yes no how much_____
Illegal drugs yes no how much_____
Marijuana yes no how much_____

CIGARETTE SMOKING: Never smoked_____ Current smoker_____ Former smoker_____

RACE: American indian or Alaska native_____ Hispanic_____ White_____ Asian_____ refused to report_____

ETHNICITY: Hispanic_____ Non-Hispanic_____ refused to report_____ **LANGUAGE:** English_____ other_____

MARITAL STATUS: Married Single Widowed Divorced Other

RELIGION:_____**PHARMACY:**_____
EMERGENCY CONTACT:_____**PHONE:**_____**RELATION:**_____
SSN:_____**EMAIL:**_____

MEDICATIONS: _____ None

_____
_____
_____
_____
_____
_____
_____
_____
_____

SURGICAL HISTORY: _____None

Procedure

_____Year_____
_____Year_____
_____Year_____
_____Year_____
_____Year_____
_____Year_____
_____Year_____
_____Year_____

ALLERGIES: _____ None

List allergies to medications Reaction

_____ _____
_____ _____
_____ _____
_____ _____

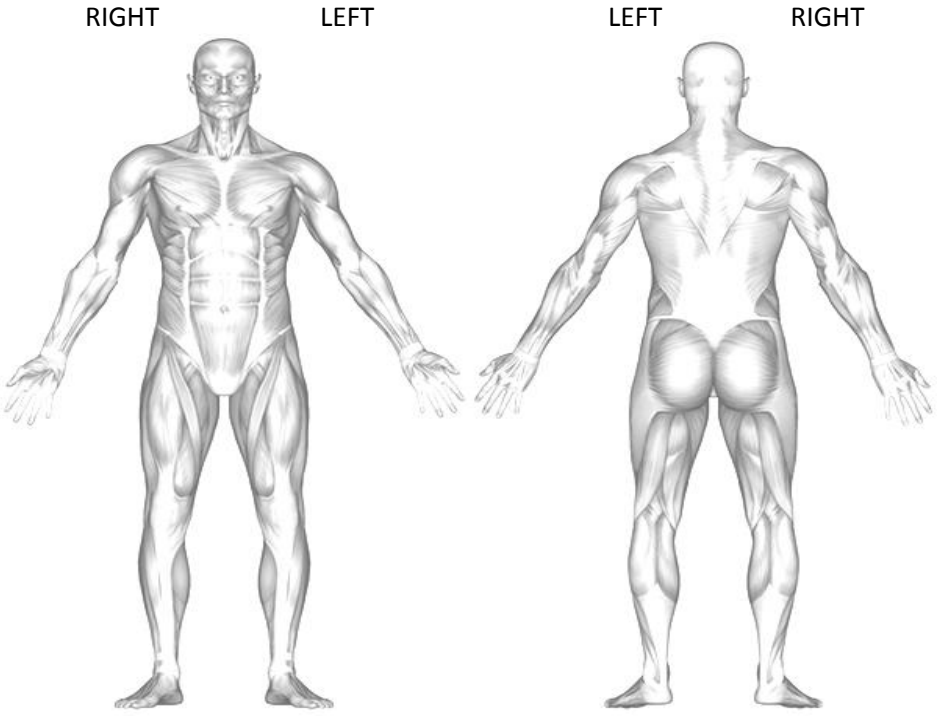
ARE YOU CLAUSTROPHOBIC YES NO

Name: _____Date:_____

Referring Doctor: _____ Primary Doctor: _____
Please describe the problem that brings you here today: _____
_____
When and **How** did the problem begin? _____
_____
Did you have a **specific** injury? Yes No If yes, what occurred: _____
_____
Where did the injury occur (work, home, mva, etc)? _____
_____
If the injury is **work-related**, did you file a Workers compensation Claim? Yes No
If disabled, when did you last work?_____
Do you have a lawyer involved with this problem? Yes No Lawyers Name: _____
What symptom(s) best describes your problem: (circle)
Pain Weakness Numbness Swelling Other_____
Do you have any of the associated problems? (circle)
Numbness Tingling Weakness Increased pain with coughing, sneezing or straining
If you have pain, please describe the pain: (circle)
Sharp Throbbing Aching Burning Stabbing Heavy Dull Electric shock Other_____
Circle the number corresponding to the intensity of your pain or other symptoms:
(No pain) 1 2 3 4 5 6 7 8 9 10 (Worse pain imaginable)

What makes your symptoms better?_____
What makes your symptoms worse?_____
Is your pain getting: better gradually worse gradually better rapidly worse rapidly staying the same

Mark the areas of your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Including all affected areas.
Numbness**: - - - - -**-, Throbbing Ache: **XXXX**, Increased Sensitivity: **o o o o**, Sharp Twinge with Motion: **///////**



Name: _____ Date: _____

TREATMENT HISTORY:

Have you seen or are you being seen by a physician for this problem? NO YES if yes, who?_____

Have you tried any of the following to help your symptoms?

Medications	YES	NO	Describe: _____
Injections	YES	NO	Describe: _____
PT/OT	YES	NO	Describe: _____
Acupuncture	YES	NO	Describe: _____
Chiropractic	YES	NO	Describe: _____
Massage	YES	NO	Describe: _____
Surgery	YES	NO	Describe: _____
Pain Management	YES	NO	Describe: _____
Neurostimulator/pump	YES	NO	Describe: _____
Other	YES	NO	Describe: _____

What studies have you had for this problem?

XRAYS	YES	NO	When? _____	Where? _____
CT	YES	NO	_____	_____
MRI	YES	NO	_____	_____
SPECT	YES	NO	_____	_____
DEXA	YES	NO	_____	_____
EMG	YES	NO	_____	_____

Review of Systems, please check if you are bothered by or have been treated for:

CONSTITUTIONAL:

_____Fever
_____Chills
_____Night Sweats
_____Feeling Poorly
_____Recent Weight Gain (_____lbs)
_____Recent Weight Loss (_____lbs)
_____Taking Blood Thinners
_____Difficulty w/ Anesthesia
_____Surgical Complications
_____Infections
_____Recent Hospitalization (dates)
_____

HEENT:

_____Loss of Vision
_____Headaches
_____Changes in Speech
_____Vision Changes
_____Difficulty Swallowing

PULMONARY:

_____Shortness of Breath
_____Cough (productive)
_____Cough (blood)
_____Wheezing

SKIN:

_____Rashes
_____Skin Wound
_____Easy Bruising
_____Bleed Easily
_____Blood Clots

CARDIAC:

_____Chest Pain
_____Irregular Heartbeat
_____Fast Heartbeat
_____Slow Heartbeat

NEUROLOGIC:

_____Confusion
_____Dizziness
_____Fainting
_____Trouble Walking
_____Suicidal Thoughts

GASTROINTESTINAL:

_____Heartburn
_____Constipation
_____Diarrhea
_____Incontinence
_____Black/Tarry Stool
_____Blood in Stool
_____Vomiting
_____Sexual Dysfunction

EXTREMITIES:

_____Neck Pain
_____Back Pain
_____Restricted Movement Neck
_____Restricted Movement Back
_____Numbness Arms/Legs/Hands/feet
_____Tingling Arms/Legs/Hands/Feet
_____Weakness Arms/Legs
_____Pain in Arms/Legs
_____Swelling in Arms/Legs