

## Patient History

Mr. S. Young FRCS, Consultant Neurosurgeon

Suite 9, The Hermitage Clinic, Dublin 21

www.spineireland.ie

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Right or Left Handed R L

Reason for Visit: \_\_\_\_\_

Date Symptoms started: \_\_\_\_\_

Are your symptoms due to an accident? No \_\_\_ Yes \_\_\_ If YES, when did it occur? \_\_\_\_\_

G.P./Referring Doctor: \_\_\_\_\_

### Past Medical History

| Surgery/Hospitalisation | Year | Remarks |
|-------------------------|------|---------|
|                         |      |         |
|                         |      |         |
|                         |      |         |
|                         |      |         |

Have you ever had a general anaesthetic? No \_\_\_ Yes \_\_\_

If the answer is YES, were there any problems? Describe: \_\_\_\_\_

Have you ever had a blood transfusion? No \_\_\_ Yes \_\_\_ If YES, what year \_\_\_\_\_

### Present Medications

| Drug | Dose | Frequency (times/day) |
|------|------|-----------------------|
|      |      |                       |
|      |      |                       |
|      |      |                       |
|      |      |                       |
|      |      |                       |

Have you been taking Aspirin? No \_\_\_ Yes \_\_\_ If YES, last taken \_\_\_\_\_ Dose/day \_\_\_\_\_

Have you been taking Plavix or Warfarin? No \_\_\_ Yes \_\_\_ If YES, last taken \_\_\_\_\_ Dose/day \_\_\_\_\_

Allergies: \_\_\_\_\_

Are you allergic to penicillin? No \_\_\_ Yes \_\_\_

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### Family History

|                     |                 |  |
|---------------------|-----------------|--|
| Heart Disease       | Epilepsy        |  |
| Diabetes            | Blood Disorders |  |
| Stroke              | Arthritis       |  |
| High Blood Pressure | Depression      |  |
| Cancer              | Spinal Disorder |  |
| Asthma              |                 |  |

### Social History

Occupation \_\_\_\_\_ Retired \_\_\_\_\_

Physically, what does your work entail? \_\_\_\_\_

Hobbies: \_\_\_\_\_

Do you smoke? No \_\_\_ Yes \_\_\_ If YES, no of cigarettes/day \_\_\_\_\_

Do you drink? No \_\_\_ Yes \_\_\_ If YES, type and number of drinks/week \_\_\_\_\_

Are you single \_\_\_\_\_ married \_\_\_\_\_ living independently \_\_\_\_\_ No. of children \_\_\_\_\_

### System Review

Tick as appropriate

|                      |  |                         |  |               |  |
|----------------------|--|-------------------------|--|---------------|--|
| Shortness of Breath  |  | Bleeding problems       |  | Numbness      |  |
| Chest Pain           |  | Abdominal Pain          |  | Paralysis     |  |
| Chronic cough        |  | Change in bowel habit   |  | Seizures      |  |
| Irregular Heart Beat |  | Urinary problems        |  | Visual loss   |  |
| Swelling of ankles   |  | Sexual dysfunction      |  | Double vision |  |
| Weight Loss          |  | Difficulty with balance |  | Hoarseness    |  |
| Weight Gain          |  | Hearing loss            |  | Depression    |  |

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_