

The Neurosurgery Center of Colorado
NEUROSURGERY QUESTIONNAIRE

Please complete the questionnaire before your clinic visits if possible. Please bring your form with you to the clinic. If you would like to complete the form in the clinic instead, or if you forget or lose your form, we will have forms available for you.

TODAY'S DATE _____

First Name _____ Middle _____ Last _____

Your age _____ The hand you use to write: Right _____ Left _____

Referring physician: _____

CHIEF COMPLAINT & PRESENT ILLNESS

What is your main complaint or symptom?

How long have you noticed it? _____

What makes it better or worse?

Do you have **headache**? Yes _____ No _____

If yes, how long have you had headaches? _____

Where in your head do you feel the pain? _____

What is the headache pain like? (Mark one or more.)

Pressure _____ sharp _____ stabbing _____ throbbing _____ aching _____

pounding _____ other _____

REVIEW OF SYSTEMS

Check if you have any of these **symptoms**:

GENERAL

- fatigue _____
- problems sleeping _____
- general body weakness _____

EYES

- light bothers your eyes _____
- blurred vision _____
- double vision _____
- spots in your vision _____
- loss of vision _____

NEUROLOGIC

- problems speaking _____
- problems with memory _____
- problems with thinking _____
- neck pain _____
- arm pain _____
- arm numbness _____
- arm weakness _____
- leg pain _____
- leg numbness _____
- leg weakness _____
- problems with balance _____
- seizures _____
- black out spells _____

MOOD

- anxiety _____
- depression _____
- panic attacks _____

SKIN

- rash _____
- new skin lesion(s) _____

HEENT

- dizziness _____
- vertigo (spinning) _____
- numbness or pain in your face _____
- ringing in your ears _____
- decrease or loss of hearing _____
- hearing aids _____
- hoarseness in your voice _____
- problems swallowing _____
- sinus problems _____
- dentures _____
- nose bleeds _____

RESPIRATORY

- cough _____
- shortness of breath _____
- sleep apnea _____

CARDIAC

- chest pain _____
- palpitations _____
- murmur _____

GASTROINTESTINAL

- poor appetite _____
- nausea _____
- vomiting _____
- abdominal pain _____
- diarrhea _____
- constipation _____
- bloody or tarry stools _____
- hemorrhoids _____

GENITOURINARY

- kidney infection _____
- stones _____
- urinary frequency _____
- bladder problems _____
- prostate problems (males) _____

MUSCULOSKELETAL

- joint swelling _____
- joint stiffness _____
- pain in joints _____
- fractures _____

PERIPHERAL VASCULAR

- swelling _____
- varicose veins _____
- leg cramps _____

ENDOCRINE

- thyroid problems _____
- diabetes _____
- night chills _____

HEMATOLOGIC/LYMPHATIC

- anemia _____
- easy bruising _____
- easy bleeding _____
- swelling of lymph glands _____

Any other symptoms?

MEDICAL HISTORY

Do you have any of these **medical illnesses**?

- | | | | |
|-----------------------|-------|-------------------|-------|
| • asthma | _____ | • ulcers | _____ |
| • emphysema | _____ | • kidney disease | _____ |
| • bronchitis | _____ | • Lupus | _____ |
| • tuberculosis | _____ | • seizures | _____ |
| • cancer | _____ | • stroke or TIA | _____ |
| • diabetes | _____ | • blood clots | _____ |
| • heart disease | _____ | • fibromyalgia | _____ |
| • high blood pressure | _____ | • arthritis | _____ |
| • liver disease | _____ | • osteoporosis | _____ |
| • hepatitis | _____ | • chronic fatigue | _____ |
| • gastric reflux | _____ | | |

List all the **surgeries** you have had in the past:

List all your **current medications**:

Are you **allergic** to any **medications, latex** or **tape**? Yes ____ No ____ If yes, please list:

FAMILY HISTORY

Have members of your family such as **grandparents, parents, brothers, sisters, or children** had any serious illnesses? If so, please list:

SOCIAL HISTORY

Are you: single ____ married ____ widowed ____

Are you: a homemaker ____ employed outside the home ____ retired ____ on disability ____

If employed outside the home, what type of work? _____

Do you **smoke**? Yes ____ No ____ How much per day? _____ How many years? _____

Your signature: _____