



New Patient Information/Questionnaire

Neuroendovascular

PHYSICIAN INFORMATION

Referring Physician's Name: _____ Practice Name: _____
 Primary Care Physicians Name: _____ Practice Name: _____

MEDICAL DECISION MAKING

Health Care Decision Maker (in the event the patient is incapacitated):

Name/Relationship to patient: _____ Legally appointed: Yes N
 Phone number: _____ (if yes, please provide documentation)

MEDICATIONS

List all medication you are currently taking (Also include non-prescription drugs with dosages):

Medication	Dosage (mg)	Frequency	Medication	Dosage (mg)	Frequency

DRUG ALLERGIES

Do you have any drug allergies?

- No know drug allergies
- Yes (please list drug and reaction below)
 1. _____
 2. _____
 3. _____

Allergic to **shellfish** or **X-ray dye**? Yes No (List reaction below)
 Allergic to **Latex**? Yes No (List reaction below)
Shellfish or Xray dye reaction: _____
Latex reaction: _____

PHARMACY INFORMATION

Pharmacy: _____ Pharmacy Phone #: _____

PAST MEDICAL HISTORY

List all major illnesses and conditions you have ever been diagnosed with (ex: High Blood Pressure, Heart Disease, Diabetes, etc.): _____

Past Surgical History:

<u>Surgery</u>	<u>Year</u>	<u>Surgery</u>	<u>Year</u>
_____	_____	_____	_____
_____	_____	_____	_____

REVIEW OF SYSTEMS

Have you had or are you having problems with any of the following? (Please check all that apply to you.)

General: Fevers Chills Sweats Fatigue Weight Loss/Gain Sleep Disturbance

Cardiovascular: Palpitations Chest pain Fainting Ankle Swelling Breathing Difficulty

Musculoskeletal: Joint Pain/Swelling Muscle Pain/Weakness Trauma/Fractures

Respiratory: Cough Wheezing Coughing Up Blood Shortness of Breath Asthma

Neurologic: Numbness Paralysis Seizures Migranes/Headaches Memory Loss

Gastrointestinal: Constipation Indigestion Nausea/Vomiting Change in Bowel Habits Abdominal Pain
 Bloody Stool Jaundice

Hematologic/Lymphatic: Abnormal Bruising Bleeding Enlarged Lymph Nodes

Genitourinary: Urinary Frequency Painful Urination Blood in Urine Bladder Control Pelvic Pain

Reproductive: Abnormal Menstral Period Pain with Intercourse Sexual Dysfunction
 Sexual Transmitted Disease

Ear/Nose/Throat: Hearing Loss Earache Ringing in Ears Nosebleeds

Skin: Rash Itching/Dryness Ulcers/Sores Hives Skin Changes

Eyes: Blurry Vision Blindness Eye Pain/Discharge Sensitivity to Light

SOCIAL HISTORY

Do you live alone? Yes No If **No**, with whom do you share a household? _____

Do you exercise? Yes No If **Yes**, how often? _____ Type: _____

Do you use tobacco products? Yes No If **Yes**, packs per day? _____ Number of years? _____

If **No**, have you ever? _____ When did you Quit? _____

Do you use smokeless tobacco? Yes No If **Yes**, packs per day? _____ Number of years? _____

If **No**, have you ever? _____ When did you Quit? _____

Do you drink alcohol? Yes No If **Yes**, how many drinks per week? _____ Wine _____ Beer _____ Liquor

Do you use recreational drugs? Yes No If **Yes**, use per week? _____ Type: _____

Do religious beliefs prevent you from receiving blood or blood products? Yes No

Are you currently working? Yes No

If yes, what is your occupation? _____