UNC HEALTH Rex

NC Neurosurgery & Spine New Patient Questionnaire

PHYSICIAN INFORMATION

Referring Physicians Name: _____ Referring Practice Name: _____

Primary Care Physician Name: _____ Primary Care Practice Name: _____

ACCIDENT INFORMATION

If your visit is due to a Worker's Compensation Claim, you must have a referral and your visit must be pre-approved. Failure to provide this information will result in your appointment being rescheduled.

Is your visit related to a recent Job / Automobile Accident? ☐ Yes ☐ No

If **YES**, Date of Injury/Accident: _____ **Type of Accident**: ☐ Job ☐ Automobile

Brief Description of Accident: _____

Are you represented by an Attorney? ☐ Yes ☐ No Name:_____ Phone #: ( )

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)

MEDICAL HISTORY

Chief Complaint (Describe the reason for your visit and/or your most disabling/severe pain):

_____

How and When did your pain begin? Month:_____ Year:_____

Height: _____ **Weight:** _____

ALLERGIES

Do you have any drug allergies?

☐ **No** known drug allergies

☐ **Yes** (please list drug and reaction below)

1. _____
2. _____

Allergic to **shellfish** or **X-ray dye**? ☐ Yes ☐ No (List reaction below)

Allergic to **Latex**? ☐ Yes ☐ No (List reaction below)

Shellfish or X-ray dye reaction: _____

Latex reaction: _____

PHARMACY INFORMATION

Pharmacy: _____ Location: _____

MEDICATIONS

Please list or request that our front desk copy your medication list upon check-in. (include non-prescription drugs with dosages):

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

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

Please list prior surgeries and the year

_____ _____

_____ _____

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

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
Gatrointestinal: ☐ Constipation ☐ Indigestion ☐ Nausea/Vomiting ☐ Change in Bowel Habits ☐ Abdominal Pain ☐ Bloody Stool ☐ Jaundice
Hematologic/Lymphatic: ☐ Abnormal Brusing ☐ 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

FAMILY HISTORY

Please check all of the following that apply to your family members.

Relationship	Status	Asthma	Anesthesia Problems	Ataxia	Bleeding Disorder	Blood Clots (DVT)	Cancer	COPD	Dementia	Diabetes	Emphysema	Heart Disease	Hypertension	Migraines	Multiple Sclerosis	Neurofibromatosis	Neuropathy	Osteoprosis	Parkinsonism	Seizures	Stroke	Tyroid Disease	Ulcers
Mother	____Alive ____Deceased																						
Father	____Alive ____Deceased																						
Sister	____Alive ____Deceased																						
Brother	____Alive ____Deceased																						

Other significant family history not listed:

_____