Alamo Neurosurgical Institute

ALAMO NEUROSURGICAL INSTITUTE
414 W SUNSET, SUITE 205
SAN ANTONIO, TEXAS 78209
WWW.ANI-ONLINE.COM

OFF: 210.564.8300 FAX: 210.564.8399

PATIENT INFORMATION SHEET

Patient Name (Last, First, Mi):_____

SSN:_____ Date of Birth:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Telephone (home):_____ (cell):_____

E-mail Address:_____

Marital Status:_____ Spouse Name:_____ DOB:_____

Parent (If under 18 years)/Guardian Name:_____

Driver's License Number:_____

ETHNICITY
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Declined

RACE
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ Caucasian
- ☐ Declined

LANGUAGE
- ☐ English
- ☐ French
- ☐ Indian
- ☐ Japanese
- ☐ Spanish
- ☐ Declined

Employer Name:_____

Supervisor Contact Name:_____ Phone #_____

Emergency Contact:_____ Phone #_____

Referring Doctor:_____ Phone #_____

Primary Care Physician:_____ Phone #_____

Patient Name:_____ Date of Birth:_____

MEDICAL HISTORY

FAMILY HISTORY

Do you have any MEDICAL HISTORY that runs in your family? (Parents/Siblings/Extended Family) ☐ YES ☐ NO

☐ CANCER	Father	Mother	Brother/Sister	Ext. Family _____
☐ DIABETES	Father	Mother	Brother/Sister	Ext. Family _____
☐ HEART ATTACH	Father	Mother	Brother/Sister	Ext. Family _____
☐ HIGH CHOLESTEROL	Father	Mother	Brother/Sister	Ext. Family _____
☐ HYPERTENSION	Father	Mother	Brother/Sister	Ext. Family _____
☐ STROKE	Father	Mother	Brother/Sister	Ext. Family _____
☐ THYROID	Father	Mother	Brother/Sister	Ext. Family _____
☐ _____ (Other)	Father	Mother	Brother/Sister	Ext. Family _____

PATIENT HISTORY

AGE:_____ HEIGHT:_____ WEIGHT:_____

Do you currently use TOBACCO? ☐ YES ☐ NO

If yes how many packs per day?_____ How many years of use?_____

Do you have a previous use of TOBACCO? ☐ YES ☐ NO

If yes how many packs per day?_____ How many years of use?_____

Do you consume ALCOHOL? ☐ YES ☐ NO

Frequency: ☐ Daily ☐ Weekly ☐ Monthly How many consumed?_____

Are you at risk for AIDS? ☐ YES ☐ NO

Have you ever had a BLOOD TRANSFUSION? ☐ YES ☐ NO If yes what year?_____

Please list ALL MEDICATIONS that you are ALLERGIC to (include latex or other allergies….)

_____

Please list ALL MEDICATIONS AND DOSAGE that you are currently taking (including aspirin and ibuprofen….)

_____

Please list ALL CURRENT and PAST Medical History (examples: COPD, diabetes, high blood pressure, high cholesterol….)

_____

Please list ALL PREVIOUS SURGICAL PROCEDURES and DATES (please list)

_____

_____

Patient Name:_____ Date of Birth:_____

REVIEW OF SYSTEMS

PLEASE CHECK ANY OF THE FOLLOWING BOXES THAT APPLY TO
"YOUR CURRENT SYMPTOMS"

GENERAL:

- ☐ Anorexia
- ☐ Appetite Loss
- ☐ Chills
- ☐ Dietary Changes
- ☐ Excessive Crying
- ☐ Fatigue
- ☐ Fever
- ☐ Medication Changes
- ☐ Night Sweats
- ☐ Obesity
- ☐ Weight Gain greater than 10lbs
- ☐ Weight Loss greater than 10lbs

SKIN:

- ☐ Bruising
- ☐ Dryness
- ☐ Excessive Sweating
- ☐ New Lesions
- ☐ Rash
- ☐ Skin Color Changes

NECK:

- ☐ Neck Mass
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Swollen Glands

HEENT:

- ☐ Blurred Vision
- ☐ Headache
- ☐ Head Injury
- ☐ Color Blindness
- ☐ Decreased Night Vision
- ☐ Double Vision
- ☐ Excessive Tearing
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Visual Disturbances
- ☐ Visual Loss
- ☐ Hearing Loss
- ☐ Deafness
- ☐ Decreased Hearing
- ☐ Ear Discharge
- ☐ Ear Infection
- ☐ Ear Pain
- ☐ Earache
- ☐ Ringing in Ears
- ☐ Tinnitus
- ☐ Spinning Sensation
- ☐ Vertigo
- ☐ Nose Bleed
- ☐ Frequent Colds
- ☐ Nasal Congestion
- ☐ Rhinitis
- ☐ Seasonal Allergies
- ☐ Sinus Pain
- ☐ Bleeding Gums
- ☐ Hoarseness
- ☐ Oral Ulcers
- ☐ Sore Throat
- ☐ Voice Changes

RESPIRATORY:

- ☐ Chronic Cough
- ☐ Cough
- ☐ Decrease Exercise Tolerance
- ☐ Snoring
- ☐ Difficulty Breathing
- ☐ Dyspnea
- ☐ Hemoptysis
- ☐ Sputum Production
- ☐ Wheezing

CARDIOVASCULAR:

- ☐ Chest Pain
- ☐ Calf cramps
- ☐ Difficultly Breathing on Exertion
- ☐ Difficulty Breathing Lying Down
- ☐ Fainting/Blacking Out
- ☐ Edema (swelling)
- ☐ Irregular Heart Beat
- ☐ Abnormal Blood Pressure
- ☐ Elevated Blood Pressure
- ☐ Hypertension
- ☐ Night Cramps
- ☐ Palpitations
- ☐ Rapid Heart Beat
- ☐ Leg Pain and or Swelling
- ☐ Phlebitis
- ☐ Shortness of Breath
- ☐ Swelling of Extremities

Patient Name:_____ Date of Birth:_____

GASTROINTESTINAL:

- ☐ Abdominal Mass
- ☐ Abdominal Pain
- ☐ Black, Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Bowel Movement
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Dysphagia
- ☐ Food Intolerance
- ☐ Gas
- ☐ Hematemesis
- ☐ Heartburn
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Vomiting
- ☐ Vomiting Blood

MUSCULOSKELETAL:

- ☐ Arm Pain
- ☐ Backache
- ☐ Back Pain
- ☐ Calf Pain
- ☐ Claudication
- ☐ Decreased Range of Motion
- ☐ Fasciculations
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Muscle Atrophy
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Myalgia
- ☐ Swelling of Extremities

NEUROLOGICAL:

- ☐ Auras
- ☐ Decreased Memory
- ☐ Difficulty Speaking
- ☐ Dizziness
- ☐ Dysarthria
- ☐ Dysesthesia
- ☐ Fasciculations
- ☐ Fainting
- ☐ Focal Neurological Symptoms
- ☐ Incoordination
- ☐ Loss of Consciousness
- ☐ Paresthesia/Numbness
- ☐ Seizures
- ☐ Syncope
- ☐ Spinning Sensation
- ☐ Stroke
- ☐ Tremor
- ☐ Unusual Sensation
- ☐ Unsteadiness
- ☐ Vertigo
- ☐ Visual Changes
- ☐ Weakness
- ☐ Weakness in Extremities

PSYCHIATRIC:

- ☐ Anxiety
- ☐ Change in Sleep Patterns
- ☐ Delusions
- ☐ Depression
- ☐ Early Awakening
- ☐ Fearful
- ☐ Hallucinations
- ☐ Hypersomnia
- ☐ Inability to Concentrate
- ☐ Mood Changes
- ☐ Insomnia
- ☐ Panic Attacks

ENDOCRINE:

- ☐ Appetite Changes
- ☐ Cold Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Hair Changes
- ☐ Heat Intolerance
- ☐ Hot Flashes
- ☐ Libido Change
- ☐ Sexual Dysfunction
- ☐ Thyroid Problems

HEMATOLOGY:

- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Blood Clots
- ☐ Easy Bruising
- ☐ Enlarges Lymph Notes
- ☐ Epitasis
- ☐ Nose Bleed
- ☐ Petechiae
- ☐ Prolong Bleeding
- ☐ Spontaneous Bleeding

Patient Name:_____ Date of Birth:_____

CURRENT AND PREVIOUS NON-SURGICAL TREATMENT

Please fill in any of the below treatments you have undergone for you current symptoms/injury.

CHIROPRACTIC TREATMENT: ☐ YES ☐ NO Date of Treatment: (range)_____

Treating Physician Name:_____

Phone No:_____ Fax No:_____

PHYSICAL THERAPY: ☐ YES ☐ NO Date of Treatment: (range)_____

Treating Physician Name:_____

Phone No:_____ Fax No:_____

PAIN MANAGEMENT: ☐ YES ☐ NO Date of Treatment: (range)_____

Treating Physician Name:_____

Phone No:_____ Fax No:_____

EMG/NCV (nerve) STUDY: ☐ YES ☐ NO Date of Treatment: (range)_____

Ordering Physician Name:_____

Phone No:_____ Fax No:_____

OTHER STUDIES:_____ Date of Treatment: (range)_____

Ordering Physician Name:_____

Phone No:_____ Fax No:_____

Patient Name:_____ Date of Birth:_____

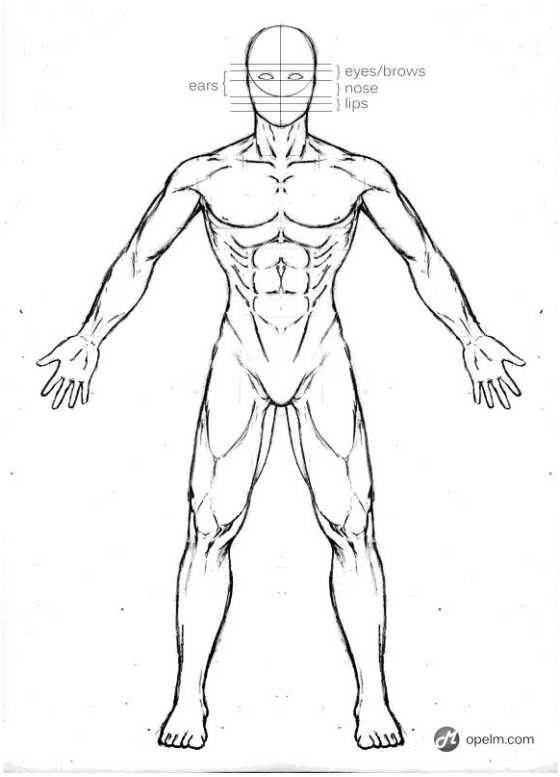
PAIN DRAWING AND PAIN RATING SCALE

Using the drawing and symbols below….
mark the appropriate areas of the body that you are CURRENTLY EXPERIENCING PAIN. Multiple symbols may be used in the same area as the symbols indicate the symptom type.

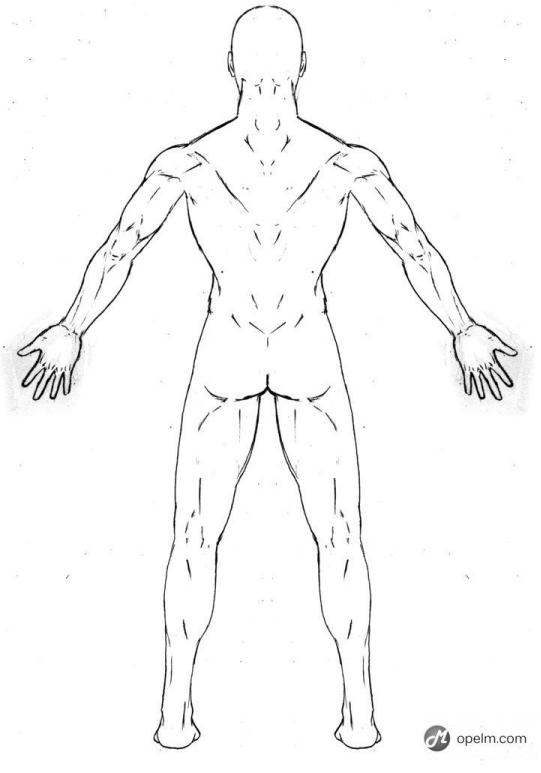
SYMBOLS

(describes type of pain)

ACHE	BURNING	NUMBNESS	PINS AND NEEDLES	STABBING
AAAA	●●●●	○○○○	| | | | |	VVVV



FRONT



BACK

Using the scale below rate your **PAIN LEVEL** by circling the appropriate number

1----------2----------3----------4----------5----------6----------7----------8----------9----------10

slight mild medium severe excruciating

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MEDICAL RECORDS AUTHORIZATION AND RELEASE FORM

I hereby authorize ALAMO NEUROSURGICAL INSTITUTE, PA and staff permission to obtain and use any and all medical records necessary for the purpose of my treatment.

Patient Name	
Date of Birth	
Social Security #	
Address	
Telephone #	
Signature	
Date	