ANI SPINE + BRAIN SURGERY

Alamo Neurosurgical Institute
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PATIENT INFORMATION SHEET

PATIENT NAME:______________________________ DATE:______________

Address:____

City:______________ State:______ Zip:________ Email:______________

Home #:______________________ Cell #:______________________

Date of Birth:_____/_____/______ Age:______________ ❑ Male ❑ Female

Social Security #:_____/_____/______ Driver License #:______________ ❑ Married ❑ Single ❑ Divorced

For a MINOR CHILD please give names of:

Father:______________ Mother:______________ Guardian:______________

(Signature of one) ____
Fathers Signature / Guardian Signature / Mothers Signature

Spouse Name:______________________ Date of Birth:______________

Ph #:______________________ Spouse Emergency Contact? ❑ Yes ❑ No

If No, Emergency Contact:______________________ Ph #:______________

Employer:______________________ Occupation:______________

Work Address:____

City:______________ State:______ Zip:________ Work Ph #:______________

Referring Physician:______________________ Ph #:______________

Primary Care Physician:______________________ Ph #:______________

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

Date:______________

Patient Name:________________________________

FAMILY HISTORY

Does MEDICAL HISTORY run in your family? ❑ No ❑ Yes

❑ Cancer	❑ Father	❑ Mother	❑ Brother/Sister	❑ Ext. Family __________
❑ Diabetes	❑ Father	❑ Mother	❑ Brother/Sister	❑ Ext. Family __________
❑ Heart Attack	❑ Father	❑ Mother	❑ Brother/Sister	❑ Ext. Family __________
❑ High Blood Pressure	❑ Father	❑ Mother	❑ Brother/Sister	❑ Ext. Family __________
❑ High Cholesterol	❑ 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 __________

Do not leave this blank (Please Approximate)

Height__________' Feet__________" Inches Weight __________

SOCIAL HISTORY

Tobacco Use: ❑ No ❑ Previous User for _______years ❑ Current Smoker ________packs per day

Alcohol Use: ❑ No ❑ Occasional (social) ❑ Moderate (monthly/weekly) ❑ Heavy (daily)

MEDICAL HISTORY Do any of the below apply? ❑ No ❑ Yes

- ❑ High Blood Pressure
- ❑ Heart Attack
- ❑ Stroke
- ❑ Bleeding Disorder
- ❑ High Cholesterol
- ❑ Diabetes
- ❑ COPD / Lung Emphysema
- ❑ Sleep Apnea
- ❑ Thyroid
- ❑ History of DVT or PE
- ❑ GERD / Acid Reflux
- ❑ Cancer(type):__________
- ❑ Other:__________
- ❑ Other:__________
- ❑ Other:__________

PAST SURGICAL HISTORY

Have you had prior Spinal Surgery? ❑ No ❑ Yes

❑ Neck Date:__________________Surgeon:________________________________

❑ Back Date:__________________Surgeon:________________________________

Check ALL procedures that apply.

- ❑ Pacemaker:__________(year)
- ❑ CABG:__________(year)
- ❑ Appendectomy:__________(year)
- ❑ Gallbladder:__________(year)
- ❑ Hernia:__________(year)
- ❑ Hip Replacement:__________(year)
- ❑ Knee Surgery:__________(year)
- ❑ Shoulder Surgery:__________(year)
- ❑ Hysterectomy:__________(year)
- ❑ C-Section:__________(year)
- ❑ Cancer Surgery:__________(year)
- ❑ Tonsillectomy:__________(year)
- ❑ Kidney Stones:__________(year)
- ❑ Other:__________
- ❑ Other:__________
- ❑ Other:__________
- ❑ Other:__________
- ❑ Other:__________

Date:____________________

Patient Name:______________________________

MEDICATIONS *(please list MEDICATIONS, DOSE and HOW TAKEN)*

1. Medication Name ____________, Strength/Dosage ____________, Frequency ____________
2. ____________, ____________, ____________
3. ____________, ____________, ____________
4. ____________, ____________, ____________
5. ____________, ____________, ____________
6. ____________, ____________, ____________
7. ____________, ____________, ____________
8. ____________, ____________, ____________

ALLERGIES TO MEDICATIONS *(List all reactions, this could be of life saving importance)*

1. Medication Name ____________, Reaction ____________
2. ____________, ____________
3. ____________, ____________
4. ____________, ____________
5. ____________, ____________
6. ____________, ____________
7. ____________, ____________
8. ____________, ____________

Date:____________________

Patient Name:______________________________________

REVIEW OF SYSTEMS *(Please check all that apply)*

Do you have a history of Hepatitis?	❑ No ❑ Yes	
Do you have a history of HIV?	❑ No ❑ Yes	
Are you at risk of HIV exposure?	❑ No ❑ Yes	
Have you had a Blood Transfusion?	❑ No ❑ Yes	If yes what year___________

GENERAL:
- ☐ Anorexia
- ☐ Appetite Loss
- ☐ Chills
- ☐ Dietary Changes
- ☐ Fatigue
- ☐ Fever
- ☐ Medication Changes
- ☐ Night Sweats
- ☐ Obesity
- ☐ Weight Gain >10lbs
- ☐ Weight Loss > 10lbs

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

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

RESPIRATORY:
- ☐ Cough
- ☐ Decrease Exercise Tolerance
- ☐ Snoring
- ☐ Difficulty Breathing
- ☐ Bloody Cough (Hemoptysis)
- ☐ Wheezing

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

PSYCHIATRIC:
- ☐ Anxiety
- ☐ Change in Sleep Patterns
- ☐ Delusions
- ☐ Depression
- ☐ Early Awakening
- ☐ Fearful
- ☐ Hallucinations
- ☐ Inability to Concentrate
- ☐ Mood Swings/Irritability
- ☐ Insomnia
- ☐ Panic Attacks

HEMATOLOGY:
- ☐ Anemia
- ☐ Blood Clots
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Nosebleed
- ☐ Petechiae
- ☐ Prolonged Bleeding
- ☐ Spontaneous Bleed

HEENT:
- ☐ Headache
- ☐ Blurred Vision
- ☐ Head Injury
- ☐ Color Blindness
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Visual Disturbances
- ☐ Visual Loss
- ☐ Hearing Loss
- ☐ Deafness
- ☐ Ear Discharge
- ☐ Ear Infection
- ☐ Ear Pain
- ☐ Earache
- ☐ Ringing in Ears
- ☐ Vertigo
- ☐ Seasonal Allergies
- ☐ Sinus Pain
- ☐ Bleeding Gums
- ☐ Hoarseness
- ☐ Oral Ulcers
- ☐ Sore Throat
- ☐ Voice Changes
- ☐ Facial Pain
- ☐ Facial Numbness
- ☐ Light Sensitivity
- ☐ Sound Sensitivity

GASTROINTESTINAL:
- ☐ Abdominal Mass
- ☐ Abdominal Pain
- ☐ Black, Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Bowel Movement
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Gas
- ☐ Vomiting Blood
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Vomiting

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

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

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

Date:_____________________________

Patient Name:_______________________________________

HEALTH INSURANCE

SELF PAY: ❑ Yes ❑ No

PRIMARY INSURANCE:_______________________________________

Name of Insured: ❑ Self ❑ Other

If Other Name:_________________________ DOB:_______________ Relationship:__________

Policy ID #:___________________________ Group #:______________________________

SECONDARY INSURANCE:_______________________________________

Name of Insured: ❑ Self ❑ Other

If Other Name:_________________________ DOB:_______________ Relationship:__________

Policy ID #:___________________________ Group #:______________________________

Date:_____________________

Patient Name:____

PREVIOUS TREATMENT HISTORY

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

Chiropractic Treatment: ❑ No ❑ Yes

Physician Name:____

Ph #:____ Fax #:_______________________________________

Physical Therapy Treatment: ❑ No ❑ Yes

Physician Name:____

Ph #:____ Fax #:_______________________________________

Pain Management Treatment: ❑ No ❑ Yes

Physician Name:____

Ph #:____ Fax #:_______________________________________

EMG/NCV Study: ❑ No ❑ Yes

Physician Name:____

Ph #:____ Fax #:_______________________________________

Date:______________________________