UCSF Medical Center

PLACE PATIENT LABEL HERE

Patient Name: _____

Dear Patient,

Welcome to the UCSF Adult Neurosurgery clinic. Our goal is to provide a comprehensive evaluation of your problem. During your visit, we will review your medical history, you will undergo a physical exam, and films will be reviewed. Our health care team consists of physician's assistants (PAs), nurse practitioners (NPs), fellows (fully-trained surgeon spending an extra year training) and your surgeon. Depending on the complexity of your problem, your visit may last less than an hour or up to two-three hours.

To prepare for your visit, please obtain copies of all reports relevant to your surgical problem and bring them with you. Examples would be reports MRI, X-rays, CT, CT myelogram, or EMG/Nerve conduction tests. If you have had any of these tests, have your hospital put the images on a CD-ROM and bring it. We need to look at the images, not just the reports. If the above listed records have already been sent/faxed to our clinic you do not need to bring duplicates to your appointment.

We strive to be detail-oriented and thorough. Your answers here will become part of the UCSF medical record and will be confidential.

Please tell us the names of the doctors taking care of you. Leave the spaces blank if not applicable.

Who is your PCP? _____

Address: _____ Phone:_____

Do you have a Medical oncologist? _____

Address: _____ Phone: _____

Do you have a radiation oncologist? _____

Address: _____ Phone: _____

Do you have a Neurologist? _____

Address: _____ Phone: _____

Do you have a Neurosurgeon? _____

Address: _____ Phone: _____

Do you have an Endocrinologist? _____

Address: Phone:

UCSF Medical Center

PLACE PATIENT LABEL HERE

Patient Name: _____

What is the **MAIN** reason for your visit here today?

_____

Have you had a flu shot this year? If so, when? _____

CURRENT MEDICATIONS

Please include all over-the-counter and herbal medications also.

Medication Name	Dosage (What is the dosage **per** pill?)	Route (by mouth, patch, injection, etc).	Frequency (per day, per week, or as needed and how many pills do you take each time?)

UCSF Medical Center

PLACE PATIENT LABEL HERE

Patient Name: _____

ALLERGIC REACTIONS TO MEDICATIONS

Have you ever had a reaction to any of the following:

YES NO Latex
YES NO Iodine
YES NO Intravenous contrast agent (used in CT scans)

Are you allergic to any medications? If so, list the medication and the reaction that you had:

MEDICATION	REACTION (circle all that apply)
Example: medication name	Anaphylaxis/shock Rash Itching Nausea/vomiting Short-of-breath Other:
	Anaphylaxis/shock Rash Itching Nausea/vomiting Short-of-breath Other:
	Anaphylaxis/shock Rash Itching Nausea/vomiting Short-of-breath Other:
	Anaphylaxis/shock Rash Itching Nausea/vomiting Short-of-breath Other:

Pain Scale

Are you currently experiencing any pain? Yes/ No

If you are experiencing any pain, on a scale of 1-10, 0 meaning no pain and 10 being the worst pain you have ever felt, how much pain are you experiencing right now? Please circle:

0 1 2 3 4 5 6 7 8 9 10

UCSF Medical Center

PLACE PATIENT LABEL HERE

Patient Name: _____

MEDICAL HISTORY

Please mark "yes" or "no" to any of the below
medical issues for which you have been diagnosed

If you have had no prior medical issues please check this box ☐

	Yes	No	Type
Asthma			
Arrhythmia			
Angina			
Allergies			
Atrial fibrillation			
Autoimmune disease			
Bleeding disorder			
Brain Tumor			
Cancer			
Chest pain			
Chronic bronchitis			
COPD (Chronic obstructive pulmonary disease)			
Cirrhosis			
Clotting disorder (Blood)			
CHF (congestive heart failure)			
Depression			
Diabetes			
DVT (deep vein thrombosis)			
Easy Bruising			
Emphysema			
GERD (gastro-esophageal disease)			
Headaches			
Heart disease			
Heart Murmur			
Heart Valve Problems			
Hepatitis Chronic			
HIV/AIDS			
Hypertension			
Kidney disease			

UCSF Medical Center

PLACE PATIENT LABEL HERE

Patient Name: _____

	Yes	No	Type
Liver disease			
Lung disease			
Melanoma			
Meningitis			
Myocardial infarction			
Nerve/muscle disease			
Other neurological disorders			
Palpitations (Heart)			
Psychiatric treatment			
Pulmonary embolus (Blood clot in lungs)			
Radiation Treatment			
Renal insufficiency			
Seizures			
Sickle cell anemia			
Sinus disorder			
Stroke			
Substance abuse			
Thyroid disease			
Ulcers			

Anything not listed above:

UCSF Medical Center

PLACE PATIENT LABEL HERE

Patient Name: _____

SURGICAL HISTORY

Please mark “yes” for any of the below surgeries patient has had and list approximate date of surgery

If you have had no prior surgeries please check this box ☐

	Date	Details
Appendectomy		
Brain surgery		
Breast surgery		
Cholecystectomy (removal of gallbladder)		
Colon surgery		
Coronary artery bypass surgery		
Gallbladder surgery		
Gamma Knife- What kind?		
Heart surgery		
Hernia repair		
Hysterectomy		
Joint replacement		
Liver surgery		
Pancreas surgery		
Prostate surgery		
Spine surgery		
Thyroid surgery		
Other:		
Other:		
Other:		
Other:		

UCSF Medical Center

PLACE PATIENT LABEL HERE

Patient Name: _____

Family history

Please check the box for any of the family members that have had problems with the medical issues listed in each column.

	Deceased?	Anesthesia problems	Brain cancer	Cancer	Clotting Disorder	High Blood Pressure	Stroke	Cardiac Stent	Heart Disease
Mother									
Father									
Sister									
Brother									
Son									
Daughter									

Social History

Please check one: Left handed ___ Right handed ___ Ambidextrous ___

Education	Less than grade school, Grade school, Middle School, High School, College Graduate
Marital Status	Single, Married, Widow(er), Divorced, Legally Separated
Do you live alone?	No, Yes
Currently employed?	No, Yes- If yes, fill in occupation:
Do you currently smoke cigarettes?	No, Yes – If yes, packs per day: For How long?
Did you previously smoke cigarettes?	No, Yes – if yes, packs per day: For How long?
Do you use smokeless tobacco?	No, Yes – If yes, how much per day: For how long?
Do you drink alcoholic beverages?	No, Yes- If yes, how many drinks/day? What kind?
Do you use any of the following drugs?	No, Yes – if yes which of the following: Cocaine, crack, LSD, Marijuana, Heroin, Other Recreational
Have you used prescription medications more often than prescribed or for a reason other than as prescribed?	No, Yes
Is your visit today in relation to a lawsuit?	No, Yes
Is this visit today in relation to a worker's comp claim?	No, Yes

UCSF Medical Center

PLACE PATIENT LABEL HERE

Patient Name: _____