Joseph A. Shehadi, M.D., FRCSC, FAANS
Northtowns Neurosurgery PLLC

Initial Medical History Form

(Please Print)

Name: _____ Age_____

Which hand do you write with _____

Have you ever seen Dr. Joseph Shehadi before? Yes No

Referring Physician_____

Address_____Phone_____

Family Physician_____

Address_____Phone_____

Other physicians you have seen for this problem_____

Address_____Phone_____

REASONS FOR THIS OFFICE VISIT

(Please check **ALL** that apply)

☐ **Pain:**

Where, exactly, is your pain? _____

How severe is the pain? (On a scale of 1-10): _____

How long have you had this pain? _____ _____ _____

What makes the pain better? (Check all that apply)

☐ Pain pills ☐ Rest ☐ leaning forward ☐ Other _____

What makes the pain worse? (Check all that apply):

☐ physical activity ☐ prolonged sitting ☐ prolonged standing
☐ coughing ☐ sneezing ☐ other _____

☐ **Numbness (decreased feeling):**

Where is your numbness? _____ ____

☐ **Weakness (loss of muscle power):**

Where is your weakness? _____

☐ **Bowel/bladder problems:**

☐ Urine incontinence (accidents) ☐ Bowel incontinence ☐ Constipation

☐ **Sexual Dysfunction** _____

What **conservative treatments** measures have you had for this problem? (check all that apply):

□ Medications □ Steroid injections □ Physical Therapy □ Chiropractic care □ TENS unit

Other_____

What **Surgical Treatments** (if any) have you had for this problem?

_____

PAST MEDICAL HISTORY (e.g. diabetes, etc)

CURRENT MEDICATIONS/SUPPLEMENTS	**Dose**	**Frequency**

Pharmacy_____ Phone_____

Do you currently take **aspirin** or products containing **aspirin**? □ Yes □ No

ALLERGIES (to any medications, food, or contrast dye) _____

_____

PAST SURGERIES/HOSPITALIZATION	**Year**	Doctor	Complications

FAMILY MEDICAL HISTORY

Are there any diseases that run in your family? (such as Diabetes, High Blood Pressure, aneurysms, etc):

_____

Family Member	**Alive**	**Deceased**	**Age**	**Health Status or Cause of Death**
Mother	_____	_____	_____	_____

Father _____ _____ _____ _____

SOCIAL HISTORY

Occupation _____

Are you currently working? □ Y □ N If not working, when was the last day you worked?_____

Tobacco:

- ❑ Yes, I smoke _____ packs of cigarettes per day and have for the past _____ years.
- ❑ No, I have never smoked cigarettes.
- ❑ No, I quit _____ years ago.

Alcohol: How many alcoholic beverages do you consume per **week**? _____

Are you at risk for AIDS (e.g. previous blood transfusion, drug abuse, sexual history)

□ Yes □ No If yes, please explain_____

Misc.:
** Is there any special information we should know about you that has not already been described? (Examples: do you have a pacemaker or any metal implantations, rare blood disorders, Jehovah's Witness etc.)_____

REVIEW OF SYMPTOMS

Have you **recently** had problems with any of the following:

Constitutional

- ❑ Fever
- ❑ Weight Loss
- ❑ Excessive Fatigue
- ❑ Night Sweats
- ❑ Loss of Appetite

Eyes, Ear, Nose, Throat, Mouth

- ❑ Hearing Loss
- ❑ Wear a Hearing Aid
- ❑ Ringing in Ears
- ❑ Eye Infections
- ❑ Eye Injuries
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Ear Pain
- ❑ Ear Infections
- ❑ Sore Throats
- ❑ Mouth Sores
- ❑ Balance Disturbance (vertigo/spinning)
- ❑ Lightheadedness
- ❑ Nosebleeds
- ❑ Nasal Congestion
- ❑ Nasal Drainage
  If yes, color _____ amount _____
- ❑ Inability to smell
- ❑ Sinus Problems
- ❑ Sinus Headaches

Cardiovascular

- ❑ Chest Pain or Angina
  If yes, date of last EKG _____
- ❑ Palpitations
- ❑ Irregular Pulse
- ❑ Heart Murmur

Genitourinary

- ❑ Urinary Tract Infection
- ❑ Painful urination
- ❑ Blood in your urine
- ❑ Difficulty starting/stopping stream
- ❑ Incontinence
- ❑ Kidney Stones
- ❑ Prostate Cancer (males)
- ❑ Endometriosis (females)
- ❑ Uterine or Cervical Cancer (female)

Musculoskeletal

- ❑ Broken Bones, List _____
- ❑ Arm or leg weakness
- ❑ Back pain
- ❑ Arm or Leg pain
- ❑ Joint pain or swelling
- ❑ Arthritis

Integumentary

- ❑ Skin Cancer
- ❑ Breast pain
  tenderness/swelling
- ❑ Nipple discharge
  Date and result of last mammogram_____

Neurological

- ❑ Fainting Spells
- ❑ Seizures
- ❑ Problems with your memory
- ❑ Disorientation
- ❑ Difficulty with your speech
- ❑ Inability to concentrate
- ❑ Double or blurred vision
- ❑ Face weakness
- ❑ Lack of coordination in arms/legs

❑ High Cholesterol

Respiratory
- ❑ Asthma
- ❑ Chronic Cough
- ❑ Emphysema
- ❑ Shortness of Breath
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Lung Cancer
- ❑ Bloody Sputum
  if yes, date of last
- ❑ Chest x-ray _____

Gastro-Intestinal
- ❑ Indigestion or pain with eating
- ❑ Trouble swallowing
- ❑ Nausea
- ❑ Vomiting
- ❑ Blood in your vomit
- ❑ Liver problems
- ❑ Jaundice
- ❑ Abdominal Pain
- ❑ Change in your bowel habits
- ❑ Ulcers or Gastritis

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Other psychiatric disorders/treatments _____

Endocrine
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ Increased appetite
- ❑ Excessive thirst or urination
- ❑ Hormone problems

Hematologic/Lymphatic
- ❑ Anemia
- ❑ Hemophilia
- ❑ Bleeding tendencies
- ❑ Persistent swollen glands/lymph nodes
  If yes, when _____
- ❑ Blood transfusion

Allergic/Immunologic
- ❑ Food allergies
  If yes, list _____
- ❑ Inhalant (nasal allergies)
- ❑ Immunologic disorders

All the information provided above is accurate and complete to the best of my knowledge.
Patient Signature _____Date _____

I have reviewed the above information with the patient.
Physicians Signature _____Date_____

PHYSICAL EXAMINATION (for office use only)

❑ Completely normal Neuro exam GA: _____

BP_____/_____ P_____ RR_____ Temp _____ Height_____ Weight_____

MSE: _____ CN: _____

Motor: _____ Sensory: _____

Reflexes: _____ _____ Hoffman's sign _____

Gait/stance_____ Cerebellum_____
Musculoskeletal_____

IMAGING & PROCEDURES (for office use only)

CT scan		**Date**
MRI scan		
X-Ray		
EMG/NCS		

CLINICAL IMPRESSION/PLAN (for office use only)**:**

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