

DR. ABHIDHA SHAH
M.Ch Neurosurgery IFAANS (USA)

Indian Cancer Society Medical Centre, Room No. 55, Cooperage, Mumbai – 21.
Tel: +91-22-22812436
Timings: Mon-Fri 5.00 pm to 8.00 pm

Patient Name: _____ Date of Birth: _____

Neurosurgeon: _____ Telephone: Home _____

Age _____ Dominant Hand: Right Left Work _____

Referring Physician:

Name _____

Address _____

Phone Number _____

Do you want us to notify this physician of your visit? ___ Yes ___ No

Primary Physician:

Name _____

Address _____

Phone Number _____

Chief Complaint (brief summary of the reason for your visit): _____

MEDICAL HISTORY

Past Surgeries: _____

Chronic Medical Illnesses: _____

Environmental Allergies: _____

Medication Allergies: _____

Current Medications

If you take more medicines than the space allotted, please list the rest on the back of this sheet.

| <u>Name</u> | <u>Dosage Frequency</u> | <u>Reason for Taking</u> |
|-------------|-------------------------|--------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Family Medical History (What illnesses run in your family): _____

Social History

Marital Status: Single Married Divorced Separated Widowed

Number of Children: _____

Occupation: _____

Background Information

| | Yes | No |
|------------------------------------|--------------------------|--------------------------|
| Complaint related to an injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Workman's Compensation? | <input type="checkbox"/> | <input type="checkbox"/> |
| Litigation pending? | <input type="checkbox"/> | <input type="checkbox"/> |
| Other physicians seen for problem? | <input type="checkbox"/> | <input type="checkbox"/> |

Review of Systems

Drink alcohol? Never Occasionally Frequently
 Do you smoke cigarettes? Yes No If yes, how many packs per day? _____
 Height _____ Weight _____

Place an X in the appropriate box if the patient has been diagnosed with any of the following illnesses:

Neurological Problems (Brain/Spine)

| | Yes | No |
|--------------|--------------------------|--------------------------|
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Tumor | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Disc Disease | <input type="checkbox"/> | <input type="checkbox"/> |

Cardiovascular Problems (Heart)

| | | |
|--------------------------|--------------------------|--------------------------|
| Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> |
| Congestive Heart Failure | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |

| | Yes | No |
|---|--------------------------|--------------------------|
| <u>Respiratory Problems (Lungs)</u> | | |
| Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Endocrine Problems (Hormones)</u> | | |
| Thyroid | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Gastrointestinal Problems (Stomach/Colon)</u> | | |
| Peptic Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Diverticulosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Rectal Bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Genitourinary Problems (Kidney/Bladder)</u> | | |
| Renal Dysfunction | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Infections | <input type="checkbox"/> | <input type="checkbox"/> |
| Urinary Tract Infections | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Dermatology Problems (Skin)</u> | | |
| | | |
| <u>Ophthalmology Problems (Eye)</u> | | |
| | | |
| <u>Hematological Problems (Blood)</u> | | |
| Bleeding Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Otolaryngology Problems (Ear, Nose, and Throat)</u> | | |
| Ear Infections | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Musculoskeletal Problems (Arthritis)</u> | | |
| Connective Tissue Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoarthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Psychiatric Problems</u> | | |
| Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| Risk for Exposure to HIV | <input type="checkbox"/> | <input type="checkbox"/> |
| Past History of Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Past Blood Transfusions | <input type="checkbox"/> | <input type="checkbox"/> |
| Possible Pregnancy (Women of Childbearing Age) | <input type="checkbox"/> | <input type="checkbox"/> |

Signature of Patient/Parent or Guardian

Today's Date

Description of Neck or Back Problems (if applicable)

Rate the intensity of your pain by placing an "X" on the line below.

No Pain Worst pain imaginable
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

What procedures have you had for the treatment of your current problem? Please check all that apply.

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Nerve Blocks | <input type="checkbox"/> Steroid Injections |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Tens Unit | <input type="checkbox"/> Psychological Counseling |
| <input type="checkbox"/> Relaxation Training | <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Chiropractic Treatment |

Please mark your sensations on the figure below using these symbols:

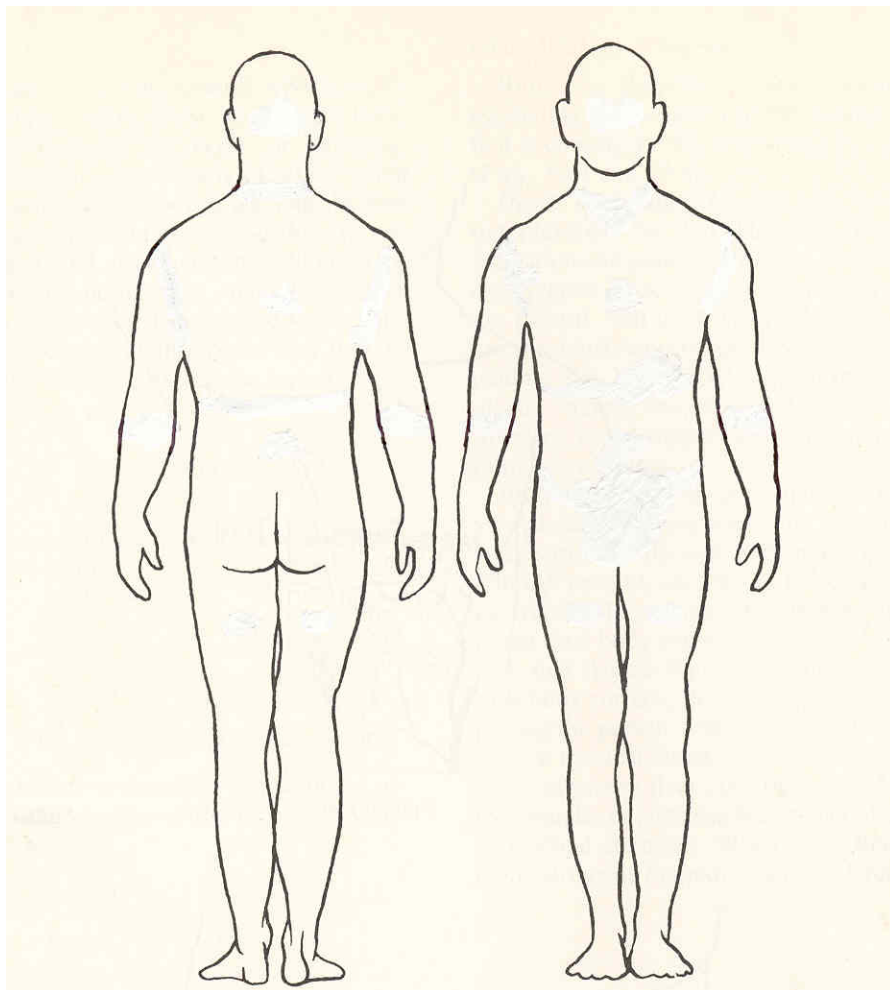
Numbness

o o o o o o
Pins/Needles

x x x x x
Burning

/////
Stabbing

+++
Aching



Physician Signature

Date