OVERLAKE MEDICAL CLINICS NEUROSURGERY

Followup Patient Intake Form

This form is meant to gather as much information as possible. Please fill it out to the best of your knowledge. If there are areas you can not or would not like to answer, please leave that area blank.

Contact Information

Full Name _____ *Date* _____

Date of Birth _____ *Age* _____ *Gender Male / Female*

*Name of Primary Care Physician*_____

General Information

(To be filled out by Medical Assistant):

*BP*_____ *HR*_____ *O2*_____ *Temp*_____ *Height*_____ *Weight*_____*lbs*

What is the reason for your visit? _____

Any new problems since previous visit?

*1.*_____

*2.*_____

3. _____

Any problems with your incision? YES/NO (circle one)

1. ☐ *Redness*
2. ☐ *Swelling*
3. ☐ *Discharge (pus or other)*

Please list, by name, all current prescription medications, over-the-counter medications, and all vitamins/supplements/herbs, including dose that you take regularly at this time.

Name	Dose	Frequency	When did you start?

Do *you have any drug, food or chemical allergies? If so, please list them below:*

Allergy	*Reaction*

No known drug allergies

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Pain Assessment

What was your pre-operation pain level?: _____(0-10)

This has improved to a _____(0-10)
This has worsened to a _____(0-10)
There has been no change _____(0-10)
Incisonal Pain Only _____(0-10)

Medication Currently Working
Medication Currently NOT Working
Pain improving since surgery
Pain worsening since surgery

Review of Systems:

CONSTITUTIONAL ☐*neg*	***EYES*** ☐*neg*	***EAR, NOSE, THROAT*** ☐*neg*	***CARDIORESPIRATORY*** ☐*neg*	***GASTROINTESTINAL*** ☐*neg*
☐*Chills*	☐*Blindness*	☐*Dizziness*	☐*Shortness of breath*	☐*Nausea*
☐*Fever*	☐*Decreased acuity*	☐*Vertigo*	☐*Cough*	☐*Vomiting*
☐*Night sweats*	☐*Blurred vision*	☐*Ringing in ears*	☐*Bloody sputum*	☐*Diarrhea*
☐*Insomnia*	☐*Double vision*	☐*Decreased hearing*	☐*Wheezing*	☐*Bloody stool*
☐*Appetite change*	☐*Eye pain*	☐*Hoarseness*	☐*Chest tightness*	☐*Constipation*
	☐*Tearing*	☐*Sinus problems*	☐*Chest pain*	☐*Abdominal pain*
	☐*Dry eyes*	☐*Nose bleeds*	☐*Palpitations*	
	☐*Redness*	☐*Oral lesions*	☐*Rapid heart rate*	

GENITOURINARY ☐*neg*	***SKIN*** ☐*neg*	***NEUROLOGIC*** ☐*neg*	***MUSCULOSKELETAL*** ☐*neg*	***PSYCHIATRIC*** ☐*neg*
☐*Incontinence*	☐*Rashes*	☐*Numbness/tingling*	☐*Joint pain*	☐*Depression*
☐*Burning urination*	☐*Easy bruising*	☐*Memory problems*	☐*Muscle ache*	☐*Anxiety*
☐*Foul odor*	☐*Sores/lesions*	☐*Headaches*	☐*Difficulty walking*	☐*Moodiness*
☐*Urinary frequency*	☐*Edema*	☐*Tremors*	☐*Leg cramping*	☐*Irritability*
☐*Blood in urine*				

ENDOCRINE ☐*neg*		***HEME/LYMPHATIC*** ☐*neg*	***ALLERGIC/IMMUNE*** ☐*neg*	
☐*Menopause*		☐*Easy Bleeding*	☐*Infection*	
☐*Altered menses*		☐*Swollen nodes*	☐*Hives*	
☐*Nipple discharge*		☐*Easy Bruising*	☐*Anaphylaxis*	
☐*Weight change*		☐*Hepatitis*		
☐*Temperature intolerance*				