Northeast Georgia
PHYSICIANS GROUP

Neurosurgery (New Patient Form)

Name:______________________________________**Date:**___________________________**DOB:**____________________

What problem are we seeing you for? _______________________ How long have you had this problem? __________________

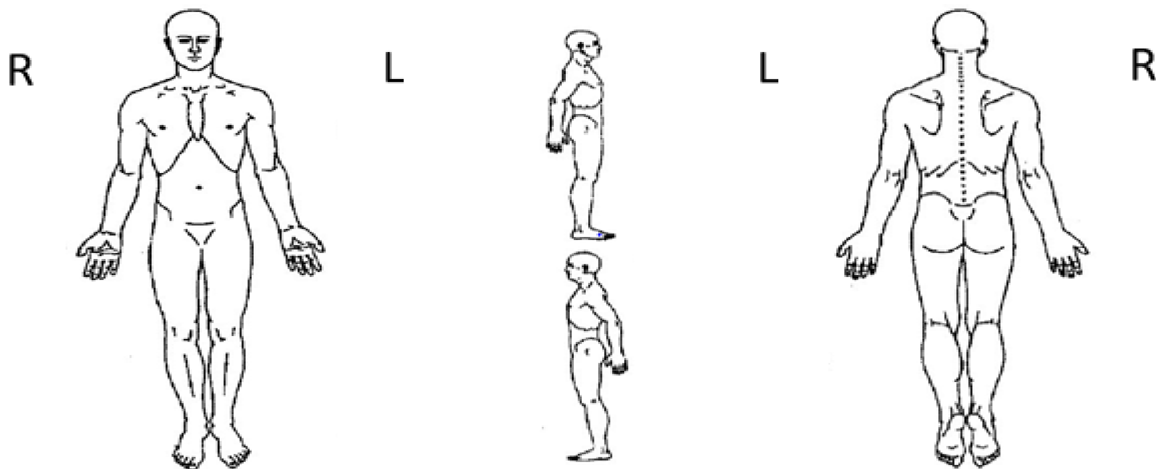
The following is important information needed to expedite surgery authorization (if needed), **PLEASE COMPLETE**:

- Who referred you? _______________________ Phone # _________________
- Primary Care Physician: _______________________ Phone # _________________
- Cardiologist: _______________________ Phone # _________________
- Pulmonologist: _______________________ Phone # _________________

Allergies? ☐ No ☐ Yes (please list allergies & reactions)____

Location: In what part of your body is your pain the worst? _____________________________

Please mark the area(s) of injury or discomfort on the chart below:



Describe the quality and character of your pain. (Check all that apply)

☐ Aching ☐ Burning ☐ Cold ☐ Electric Shock ☐ Hot/Flushed ☐ Numb ☐ Sharp
☐ Stabbing ☐ Throbbing ☐ Tingling ☐ Pins & Needles ☐ Dull ☐ Other (describe):______________

Rate the severity of your pain *at its worst* on this scale (1 = mild, 10 = worst pain of your life):

1.........2.........3.........4.........5.........6.........7.........8.........9.........10

Radiation/Referral Pattern: Does your pain travel to other locations? ☐ No ☐ Yes (where?___________________)

Describe the frequency of your pain. ☐ Daily ☐ Weekly ☐ Monthly ☐ Constant ☐ Infrequent/episodic/irregular

Timing: At what time of day (or night) is the pain at its worst?____

Aggravating/Alleviating Factors: What worsens the pain? _______________ What makes the pain better? __________________

Activity: Are you exercising, walking, stretching, etc.? ____

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CONSERVATIVE TREATMENTS: (Check any of the following treatments you have tried in the **past 12 months** for the area of discomfort)

- ☐ Physical Therapy
- ☐ Home Exercises
- ☐ Chiropractor
- ☐ Injections/Procedures
- ☐ Prior Surgery
- ☐ Medications/Cream
- ☐ Ice/Heat
- ☐ Massage Therapy
- ☐ TENS Unit
- ☐ Acupuncture

How Many Hours of Sleep do you average per night? ________ **Would you consider this quality sleep?** ☐ Yes ☐ No

How would you describe your mood? ☐ Irritable ☐ Sad ☐ Happy most of the time ☐ Other:________________________

Are you currently working? ☐ Full-Time ☐ Part-Time ☐ Not Currently Working

REVIEW OF SYSTEMS: (Check any of the following symptoms you have experienced in the **past 6 months**):

Constitutional

- ☐ Activity change
- ☐ Appetite increase
- ☐ Appetite loss
- ☐ Fever
- ☐ Malaise/Fatigue
- ☐ Weight gain
- ☐ Weight loss

Musculoskeletal

- ☐ Back Pain
- ☐ Difficulty walking
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Pain
- ☐ Neck Pain

Neurological

- ☐ Dizziness
- ☐ Weakness
- ☐ Headaches
- ☐ Light-headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Tremors
- ☐ Speech Difficulty
- ☐ Syncope

PAST MEDICAL HISTORY (Check any of the following conditions you have been diagnosed with):

- ☐ Headaches
- ☐ Implanted Devices
- ☐ Stroke
- ☐ TIA
- ☐ Carotid Artery Disease
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Abnormal Heart Rhythm
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Syncope
- ☐ High Cholesterol
- ☐ Thyroid Disease
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Cancer
- ☐ Congestive Heart Failure
- ☐ Stomach Ulcers
- ☐ Diabetes
- ☐ Low Blood Sugar
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Anemia
- ☐ Epilepsy
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Psychiatric Disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Claustrophobia

Other: ____

PAST SURGICAL HISTORY (Check any of the following surgeries you have undergone):

- ☐ Back Surgery
- ☐ Neck Surgery
- ☐ Brain Surgery
- ☐ Carotid Surgery
- ☐ Cardiac Stent
- ☐ Pacemaker
- ☐ Carpal Tunnel Repair
- ☐ Hysterectomy
- ☐ Appendectomy
- ☐ Gall Bladder
- ☐ Gastric Bypass

Other: ____

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Social History:

Alcohol use: ☐ No ☐ Yes (Frequency_________________________)

Tobacco Products: ☐ Current ☐ Former ☐ Never ☐ E-cigarettes

Currently working? ☐ No ☐ Yes (Occupation___________________)

Disability? ☐ Yes ☐ No ☐ Pending ☐ Seeking

Caffeine Beverages per day? ______________

Under stress? ☐ Yes ☐ No

Marital Status: ☐ single ☐ married ☐ divorced

FAMILY HISTORY: Do any of your blood relatives have or have they ever had any of these conditions? Please list relationship to affected individual(s):

Heart Disease________________

Hypertension________________

Stroke______________________

Back Surgery ________________

Headaches___________________

Cancer______________________

Kidney Disease_______________

Neuropathy_________________

Seizure Disorder______________

Diabetes ___________________

Brain Aneurysm______________

Psychiatric History________________

Drug Abuse______________________

Parkinson's Disease_______________

Arthritis ________________________

Trembling_______________________

Current Medications:

Retail Pharmacy:____ **Phone:**____________________

Mail-in Pharmacy:____

Please list all current medications, dosage & how many times per day you take each medication.

*****if you take multiple medications, please bring a list to your appointment.***

MEDICATION	DOSE	TIMES PER DAY
Example: Tramadol	*50 mg*	*Twice A Day*