

ANCHORAGE NEUROSURGICAL ASSOCIATES, INC.

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HISTORY SHEET

Name: _____ Age: _____ Referring Doctor: _____

Drug Allergies: Yes No Tetanus Penicillin Sulfa Codeine Morphine Demerol Aspirin
Please list any other drug allergies: _____

Medical History:

Have you ever been hospitalized? Yes No How many times? _____

Have you had any operations? Yes No If so, what for? _____

Are you on medication today? Yes No If Yes, Please complete the Medication Sheet.

Are you currently taking: Aspirin Vitamins St. John's Wort Other OTC medications: _____

Have you ever been under Pain Management? Yes No Have you ever signed a pain contract? Yes No

Diagnostic Studies: Any of the following diagnostic studies completed?

X-rays CT MRI EMG Myelogram Discogram Epidural Steroid Injection Bone Scan

Have you tried?

Bed Rest Physical Therapy Other Medical Treatments: _____

Medications Chiropractic Manipulation Alternative Treatments: _____

Describe your symptoms related to why you are being seen?

Aching Burning Stabbing Shooting Sharp Dull Headaches Other: _____

Have you had any disease associated with the following:

Lungs Heart Liver Kidney Diabetes Tuberculosis Cancer Convulsions

If so, please explain: _____

List contagious diseases contracted: _____

Any head injuries? Yes No Injury(ies) & Year(s): _____

Any fractures? Yes No Injury Site(s) & Year(s): _____

Bleeding tendency: Yes No _____

Blood transfusion? Yes No How many? _____ Year: _____ Reason: _____

Family History	Age	Health (be specific)	If deceased, age & cause of death
Mother			
Father			
Siblings			
Children			

Social History: Do you? Smoke Yes No How much? _____ How many years? _____

Drink Yes No How much? _____ How many years? _____

Have you ever been addicted to Drugs or Alcohol? Yes No

Are you: Right Handed Left Handed

Signature of Patient, Parent, Guardian, Personal or Legal Representative

Date