

ANCHORAGE NEUROSURGICAL ASSOCIATES, INC.

3831 Piper Street, Suite S450

Anchorage, AK 99508

Phone (907) 258-6999

Fax (907) 258-6247

Name _____

MEDICATIONS INFORMATION

Preferred Pharmacy:

1. _____

2. _____

If you are not using one of these pharmacies to fill your medication request, please let the staff know.

Drug Name:

Dosage:

Taking For How Long:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking any of these medications? Aspirin Tylenol Motrin Aleve Naproxen Celebrex
 Coumadin Warfarin Heparin Plavix Pradaxa Lovenox Weight Loss Medication Ma huang/Ephedra
 Supplements? Fish oil Flax seed oil Garlic Ginger Ginkgo-biloba Grape seed extract
 Chamomile Dandelion root Dong quoi Horse chestnut Hops St Johns Wort Echinacea

Is there any specific questions or concerns you need to talk to the provider about today?

Our office policy requires YOU, the patient, to provide us with a new medication list at each appointment. Our staff will not copy prior lists for you to use. If you do not bring a list or refuse to fill out a new list, your appointment may be rescheduled.

Patient Initials

REVIEW OF SYSTEMS

Positive response = circle

Eyes/Head	Vision changes	Headaches	Dizziness						
ENM&T	Hearing changes	Tinnitus	Nose bleeds						
Cardio	Chest pain	Irregular heart beat	Heart palpitations	Edema	Syncope				
Respiratory	Shortness of breath	Cough	Wheezing						
Gastrointestinal	Indigestion	Heartburn	Nausea	Abdominal pain	Bowel changes	Diarrhea	Constipation	Bloody stool	
Genitourinary	Dysuria	Hematuria	Nocturia	Decreased force/flow	Vaginal discharge				
Musculoskeletal	Arthralgia	Bursitis	Gout	Stiffness	Osteoporosis	Back pain	Neck pain		
Skin	Itching	Rash	Hives	Skin Cancer					
Neurologic	Seizures	Epilepsy	Numbness	Palsy	Stroke	Muscle spasm	Speech	Tingling	
Psychological	Anxious	Depressed	Stress						
Endocrine	Breast masses-discharge		Diabetes	Steroid use					
Heme/Lymph	Anemia	Bruise easily	Bleeding	Swollen glands					
Allergy/Immun	Cancer	Seasonal Allergies							
Constitutional	Appetite changes	Weight changes	Fever	Chills	Malaise	Fatigue			
_____	All Other Systems	(Negative)							

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

Date _____

Office Staff Processor _____