UW Medicine
NORTHWEST HOSPITAL & MEDICAL CENTER
NORTHWEST NEUROSURGERY

Patient Label

Health History Form

DATE: _____

NAME: Last _____ **First** _____ **MI**_____**Gender:** ☐ **M** ☐ **F Birthdate:** _____

REASON FOR VISIT: _____

Allergies:	**Medication or Substance**	**Reaction**
☐ No Allergies		

Current Medications:	**Label – Name**	**Dose**	**Frequency**
OR			
☐ See Attached List			

Treatment and Imaging

		Yes	**No**		
Previous	Physical Therapy	☐	☐	When _____	Where _____
Treatment:	Reduction of Activities	☐	☐	When _____	Where _____
(if you have a	Steroid Injection	☐	☐	When _____	Where _____
spinal problem)	Anti-Inflammatory Medication	☐	☐	When _____	Where _____
	Other	☐	☐	When _____	Where _____
Imaging:	Type: _____	☐	☐	When _____	Where _____
	Type: _____	☐	☐	When _____	Where _____
	Type: _____	☐	☐	When _____	Where _____

Social History

☐ Single ☐ Married (their name: _____) ☐ Domestic Partner (their name: _____) # Kids _____

Do you use tobacco products? ☐ Daily ☐ Some Days ☐ Quit ☐ Passive (around cigarette smoke) ☐ Never
Packs per Day _____ Years Smoked _____ Date Quit _____
Type(s) of Tobacco: ☐ Cigarettes ☐ Cigars ☐ E-Cigarettes ☐ Chew ☐ Snuff

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit Date Quit _____
Drinks per Day _____ Drinks per Week _____ Type: ☐ Beer ☐ Wine ☐ Liquor

Do you use recreational drugs? ☐ Never ☐ Yes – Use per Week _____ ☐ No ☐ Quit Date Quit _____
Have you ever used intravenous (IV) drugs: ☐ Yes ☐ No
Types: ☐ Cocaine ☐ Marijuana ☐ Methamphetamines ☐ Stimulants ☐ Heroin
☐ Depressants (downers) ☐Hallucinogens (LSD, mushrooms) ☐ Opioids

Are you sexually active? ☐ Yes ☐ No Partners: ☐ Male ☐ Female Birth Control: _____

Are you working? ☐ Yes What do you do? _____ ☐ No ☐ Retired ☐ Disabled

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Medical History — Please check box for those conditions you have now or have ever had

- ☐ A-V Malformation
- ☐ Aneurysm
- ☐ Back Pain
- ☐ Brain Tumor
- ☐ Carotid Disease
- ☐ Chiari Malformation
- ☐ Concussion
- ☐ Cushing's Disease
- ☐ Disk Problem – Cervical
- ☐ Disk Problem – Lumbosacral
- ☐ Disk Problem – Thoracic
- ☐ Endocrinopathy
- ☐ Genetic Disorders
- ☐ Hydrocephalus
- ☐ Infection
- ☐ Intracranial Hemorrhage
- ☐ Myelomeningocele
- ☐ Neuropathy – Peripheral
- ☐ Pituitary Tumor
- ☐ Pseudotumor Cerebri
- ☐ Scoliosis
- ☐ Spinal Cord Injury
- ☐ Spinal Tumor Subdural
- ☐ Hematoma/Subarachnoid Hemorrhage
- ☐ Traumatic Brain Injury

- ☐ No PMH
- ☐ Allergic Rhinitis
- ☐ Anemia
- ☐ Anesthesia Problems
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding/Clotting Disorder
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Atherosclerosis
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Gastric Ulcer
- ☐ GERD
- ☐ Glaucoma
- ☐ Headache
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV
- ☐ Hypertension
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Lipid/Cholesterol
- ☐ Lung Disease
- ☐ Musculoskeletal
- ☐ Myocardial Infarction
- ☐ Osteoporosis
- ☐ PPD
- ☐ Seizures
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Tuberculosis

☐ Other (Please list): _____

History of Hospitalizations

If you required hospitalization for an illness *other than the disease you are being seen for today* please describe below

Month/Year	Illness	Month/Year	Illness

Surgical History — Please check box for any surgery you have had, indicate the year

- ☐ No PSH
- ☐ Appendectomy (_____)
- ☐ AV Shunt (_____)
- ☐ Breast Surgery (_____)
- ☐ CABG (_____)
- ☐ Carotid Endarterectomy (__)
- ☐ Carotid Stent Placement (__)
- ☐ Carpal Tunnel Release (___)
- ☐ Cerebral Angiography (_____)
- ☐ Chiari Surgery (_____)
- ☐ Coronary Endarterectomy (____)
- ☐ Craniotomy (_____)
- ☐ Endoscopy (_____)
- ☐ Epilepsy Surgery (_____)
- ☐ Fracture Surgery (_____)
- ☐ Gall Bladder (_____)
- ☐ Implant - VNS (_____)
- ☐ LP Shunt (_____)
- ☐ Neuro-Endoscopy (_____)
- ☐ Radiosurgery (_____)
- ☐ Spinal Cord Stimulator (___)
- ☐ Spine Surgery (_____)
- ☐ Splenectomy (_____)
- ☐ Trauma Surgery (_____)
- ☐ Tumor Resection – Brain (_____)
- ☐ Tumor Resection – Spine (_____)
- ☐ Ulnar Nerve Decompression (_____)
- ☐ Vascular (_____)
- ☐ Vertebroplasty (_____)
- ☐ VP Shunt

☐ Other (Please list): _____

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Family History–Check all that apply

Relationship	First Name	Status (circle)	No Family History	Aneurysm	Asthma	Ataxia	Brain Tumor	Cancer	Chorea	Clotting Disorder	Dementia	Depression	Early Sudden Death	Heart Disease	Hypertension	Hyperlipidemia	Melanoma	Intellectual Disability	Migraine Headaches
Mother		alive deceased																	
Father		alive deceased																	
Sister		alive deceased																	
Brother		alive deceased																	
Maternal Aunt		alive deceased																	
Maternal Uncle		alive deceased																	
Paternal Aunt		alive deceased																	
Paternal Uncle		alive deceased																	
Maternal Grandmother		alive deceased																	
Maternal Grandfather		alive deceased																	
Paternal Grandmother		alive deceased																	
Paternal Grandfather		alive deceased																	

Relationship	First Name	Status (circle)	Multiple Sclerosis	Neurofibromatosis	Neuropathy	Other Inherited	Parkinson's Disease	Seizures	Stroke	Amblyopia	Birth Defects	Blindness	Cataracts	Diabetes	Glaucoma	Lipids/Cholesterol	Macular Degeneration	Retinal Detachment	Other:
Mother		alive deceased																	
Father		alive deceased																	
Sister		alive deceased																	
Brother		alive deceased																	
Maternal Aunt		alive deceased																	
Maternal Uncle		alive deceased																	
Paternal Aunt		alive deceased																	
Paternal Uncle		alive deceased																	
Maternal Grandmother		alive deceased																	
Maternal Grandfather		alive deceased																	
Paternal Grandmother		alive deceased																	
Paternal Grandfather		alive deceased																	

****Type of Cancer or Disease:** _____

Screening

In the past two weeks, how often have you been bothered by the following? (Please circle one response per statement.)

Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed, or hopeless	Not at all	Several days	More than half the days	Nearly every day

Have you fallen in the past year? ☐ Yes ☐ No Do you have issues with balance or feeling unsteady? ☐ Yes ☐ No
Are you afraid of falling? ☐ Yes ☐ No Do you feel safe at home? ☐ Yes ☐ No

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Review of Systems (current symptoms) – please check only if these are bothering you at this time

Gastrointestinal
☐ Poor Appetite ☐ Nausea ☐ Vomiting ☐ Heartburn/Indigestion ☐ Rectal Bleeding
☐ Stomach Pain ☐ Constipation ☐ Vomiting Blood ☐ Black Tarry Stools ☐ Other: _____
☐ Diarrhea ☐ Abdominal Swelling ☐ Trouble Swallowing ☐ Other: _____ ☐ Other: _____

Constitutional ☐ Fevers ☐ Fatigue ☐ Weight Gain ☐ Weight Loss

Head / Eyes ☐ Cataracts ☐ Dry Eyes ☐ Poor Vision ☐ Color Blindness

Ears/Nose/Mouth/Throat
☐ Hearing Loss ☐ Chronic Sinus Congestion
☐ Heavy Snoring ☐ Bad Teeth

Respiratory (lungs)
☐ Cough ☐ Asthma
☐ Shortness of Breath ☐ Emphysema (COPD)

Heart ☐ Chest Pain ☐ Palpitations ☐ Irregular Heart Beat ☐ High Blood Pressure

Genitourinary ☐ Sexual Problems ☐ Burning with Urination ☐ Blood in Urine ☐ Leakage of Urine

Muscles/Bones ☐ Chronic Pain ☐ Muscle Wasting ☐ Muscle Weakness ☐ Muscle Cramping

Skin ☐ Rash ☐ Jaundice ☐ Itching ☐ Psoriasis

Neurological ☐ Headaches ☐ Seizures ☐ Confusion ☐ Tremor (shaking)

Vascular ☐ Blood Clots ☐ Varicose Veins

Psychosocial
☐ Anxiety / Nerves ☐ Abusive Relationship ☐ Sexual Difficulties ☐ Insomnia ☐ Alcohol Use
☐ Depression ☐ Feeling Worthless ☐ Want to Hurt Yourself ☐ Want to Hurt Others ☐ Drug Use

Endocrine ☐ Hot Flashes ☐ Intolerance to Heat ☐ Excessive Thirst ☐ Intolerance of Cold

Blood / Lymph ☐ Swollen Lymph Nodes ☐ Easy Bruising ☐ Easy Bleeding