Neurointerventional Service PRE-VISIT MEDICAL HISTORY AND MEDICATION FORM

PATIENT INFORMATION

Patient's Name _____

Today's Date _____

Referring Physician _____

Family Physician _____

Date of Birth _____ Age _____

Height _____ feet _____ in Weight _____

Gender _____ Marital Status _____

Number of Children _____

PERSONAL HEALTH HISTORY

What is the reason for this visit? _____

_____

_____

_____

_____

Do you have, or have you ever had, any of the following?

Please check all that apply and provide the date.

- ☐ Headache
- ☐ Dizziness
- ☐ Seizure
- ☐ Trouble with speech
- ☐ Facial droop
- ☐ Depression
- ☐ Vision problems (double vision, decreased vision)
- ☐ Weakness or numbness on one side of your body
- ☐ Back pain
- ☐ Trouble walking

- ☐ Sleep apnea
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Heart attack / Chest pain / pressure
- ☐ Heart failure
- ☐ Rapid heart beat or irregular pulse
- ☐ Diabetes / high blood sugar
- ☐ Cancer
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Stomach or bowel disorder / constipation

☐ Pain in legs when walking ☐ Skin lesions

Have you ever had any of the following brain or carotid studies?
Please check all that apply.

☐ MRI brain ☐ CT head ☐ Carotid ultrasound ☐ Angiogram

Other _____

Please list your current medications and dose:

_____
_____
_____
_____
_____

Have you ever had a reaction to the dye used in certain radiological studies?
Do you have any allergies to medication?
If yes, which medications and describe the reaction:
_____
_____

Do you currently smoke?
If yes, Number of pack(s) per day _____ Number of years _____
Have you ever smoked?
If yes, Date stopped _____
Do you have high cholesterol? Last checked _____
Do you have high blood pressure?
If yes, How many years?_____
What was the reading of your last blood pressure checked, and date if known?_____
Do you drink alcoholic beverages?
If yes, how much each day _____
Do you drink beverages containing caffeine?
If yes, how much _____
Do you exercise?
If yes, what is your exercise routine: _____
_____
_____
Occupation _____
Please describe your job tasks: _____
_____

Are you retired?
If yes, date of retirement _____
Are you disabled?
If yes, describe disability and date of disability: _____
_____
_____
_____

Describe any surgeries you have had:

Surgery _____ **Year** _____
Other health conditions: _____

FAMILY HISTORY

Do you have a history of brain aneurysm or stroke in your family?
If yes, indicate relation and age problems started _____
_____
_____
_____

Family member(s):

Relative	**Status**	**Current Age or Age at Death**	**Cause of Death**
Mother			
Father			
Sister(s)			
Brother(s)			