Piedmont Neurosurgery and Spine

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Patient survey

General Medical Information

Are you allergic to any medications? _____yes _____no

If yes, please list:_____

_____

List all medications you take:

_____

_____

_____

Have you ever had any surgery? _____yes _____no

If yes, please list:_____

_____

Do you have or have you had:

Hypertension (high blood pressure) ?	____yes	____no	
Diabetes?	____yes	____no	
Asthma?	____yes	____no	
Emphysema?	____yes	____no	
TB (tuberculosis)?	____yes	____no	
Bowel disease (Chron's or ulcerative colitis)?	____yes	____no	
Multiple Sclerosis?	____yes	____no	
Polio?	____yes	____no	
Seizures?	____yes	____no	
Stomach or Peptic ulcers?	____yes	____no	
MI (heart attack)?	____yes	____no	When?
Chest pain/angina?	____yes	____no	
Mitral valve prolapse	____yes	____no	
Rheumatic fever	____yes	____no	
Have you ever had a stroke, TIA or been paralyzed?	____yes	____no	
Have you ever had any type of Cancer?	____yes	____no	
If yes, please list what kind _____			
Do you have glaucoma?	____yes	____no	
Pancreatitis?	____yes	____no	
Kidney stones?	____yes	____no	
Do you have high cholesterol?	____yes	____no	
Do you smoke?	____yes	____no	
If yes, # packs per day _____			
Do you consume alcohol?	____yes	____no	
If yes, amount per week _____			

Marital Status _____Single _____Married _____Divorced _____Widow/Widower

Any children? _____yes _____no if yes, how many? 1 2 3 4 5 other

What is your occupation/job? _____