NEUROSURGERY ASSOCIATES OF KANSAS CHARTERED

HEALTH QUESTIONNAIRE

Patient Name _____ Patient Date of Birth/Age _____

Today's Date _____ Name of Referring Doctor _____

DESCRIBE CHIEF COMPLAINT/SYMPTOMS _____

_____

DATE SYMPTOMS STARTED _____

IF INJURY, HOW DID INJURY OCCUR? _____

_____

HEIGHT _____ WEIGHT _____

LIST ANY PAST SURGERIES

_____ DATE _____

_____ DATE _____

_____ DATE _____

PLEASE CHECK ANY PAST ILLNESSES

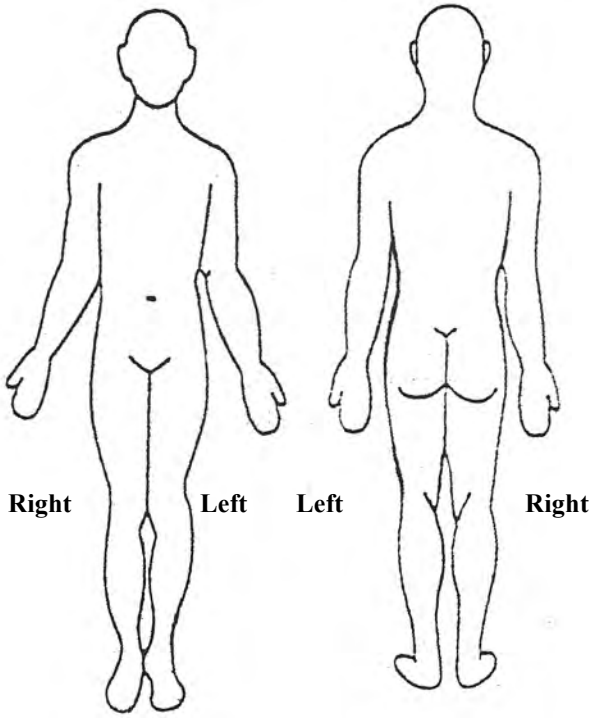
_____Cancer	_____Asthma	_____Hypertension	_____Heart Disease
_____Diabetes	_____Bronchitis	_____Rheumatic Fever	_____Kidney Problems
_____Stroke	_____Hepatitis	_____Tuberculosis	_____Drug Problem
_____Epilepsy	_____Pancreatitis	_____Thyroid Problem	_____Clotting Problem
			_____Liver Problems

PLEASE LIST ANY OTHER MEDICAL PROBLEMS _____

_____

_____

SHADE IN AREA WHERE PAIN IS LOCATED



LIST CURRENT MEDICATIONS/DOSAGES

Medication	How Many Per Day?
_____	_____
_____	_____
_____	_____
_____	_____

Do You Smoke? _____ Amount? _____

Do You Consume Alcohol? _____

Amount Per Week? _____

Have You Ever Had a Blood Transfusion? _____

PLEASE LIST ANY ALLERGIES

_____

_____

_____