HEARTLAND
NEUROSURGERY

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as complete as possible. This is very important information. Please fill out every item. It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered in to the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name_____ First_____ MI_____

Sex: ☐ Male ☐ Female Date of Birth:_____

Name of Primary Care Physician: _____

Pharmacy Preference (include location):_____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ No ☐ Yes If yes, please list below

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ No ☐ Yes

If yes, please list type of problems: _____

_____

_____

List any surgeries you have had (including dates): _____

_____

_____

_____

Have you ever been hospitalized for non-surgical reasons? ☐ No ☐ Yes

If yes, please list reasons for hospitalizations: _____

_____

CURRENT OR MOST RECENT OCCUPATION: _____