Princeton Neurological Surgery

John D. Lipani, MD, PhD, FAANS, FACS
3836 Quakerbridge Road • Suite 203 • Hamilton, NJ 08619
609-890-3400 • (Fax) 609-890-3410

PATIENT HEALTH HISTORY

Name _____ Date of Birth _____/_____/_____
Last First Middle *Month Day Year*

Address _____ Today's Date _____/_____/_____
Street City State Zip code *Month Day Year*

PREVIOUS MEDICAL HISTORY

- ☐ Aids
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding tendency
- ☐ Bronchitis/emphysema
- ☐ Chemical/drug dependency
- ☐ Depression
- ☐ Diabetes ☐ type I ☐ type II
- ☐ Epilepsy/seizures
- ☐ Eating disorder (anorexia/bulimia)
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Goiter
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Hypertension
- ☐ Hyperthyroid disease
- ☐ Hypothyroid disease
- ☐ Migraine headaches
- ☐ Multiple sclerosis
- ☐ Pacemaker
- ☐ Prostate condition
- ☐ Psychiatric disorder
- ☐ Scarlet or rheumatic fever
- ☐ Stroke
- ☐ Stomach ulcer
- ☐ Tuberculosis
- ☐ Venereal disease
- ☐ Cancer: type(s) _____

_____

☐ Other condition(s) _____

_____

_____

_____

Please list any/all past surgery including dates

Type of Surgery	Date of Surgery

ALLERGIES

Are you allergic to any medication? ☐ Yes ☐ No

Are you allergic to LATEX? ☐ Yes ☐ No

Are you allergic to shellfish or iodine? ☐ Yes ☐ No

Please list all medication allergies and symptoms

Medication Allergy	Symptoms

Please list all current medications, including over the counter, vitamins and/or herbal and natural supplements

Medication	Dosage	Frequency

SOCIAL HISTORY

Marital status: ☐ single ☐ married ☐ divorced ☐ widowed

Number of children _____ Type of employment _____

Litigation active or pending ☐ Yes ☐ No

Handedness ☐ Left ☐ Right ☐ Ambidextrous

Tobacco use ☐ Yes ☐ No If yes, # packs per day _____ # packs per week _____

Alcohol use ☐ Yes ☐ No # drinks per day _____ # drinks per week _____

Drug use ☐ Yes ☐ No Drug used _____ Date last used _____/_____/_____

Exercise level ☐ Exercise routinely ☐ Occasionally ☐ Sedentary

Family History

Mother ☐ Alive ☐ Deceased ☐ Age_____ Cause of death _____

Father ☐ Alive ☐ Deceased ☐ Age_____ Cause of death _____

Heart disease	Mother	☐ Yes ☐ No
Hypertension	Mother	☐ Yes ☐ No
Stroke	Mother	☐ Yes ☐ No
Diabetes type I / type II (circle one)	Mother	☐ Yes ☐ No
High cholesterol	Mother	☐ Yes ☐ No
Bleeding/clotting problems	Mother	☐ Yes ☐ No
Cancer	Mother	☐ Yes ☐ No
Cancer type(s)	Mother	
Heart disease	Father	☐ Yes ☐ No
Hypertension	Father	☐ Yes ☐ No
Stroke	Father	☐ Yes ☐ No
Diabetes type I / type II (circle one)	Father	☐ Yes ☐ No
High cholesterol	Father	☐ Yes ☐ No
Bleeding/clotting problems	Father	☐ Yes ☐ No
Cancer	Father	☐ Yes ☐ No
Cancer type(s)	Father	

Heart disease	Sibling(s)	☐ Yes ☐ No
Hypertension	Sibling(s)	☐ Yes ☐ No
Stroke	Sibling(s)	☐ Yes ☐ No
Diabetes type I / type II (circle one)	Sibling(s)	☐ Yes ☐ No
High cholesterol	Sibling(s)	☐ Yes ☐ No
Bleeding/clotting problems	Sibling(s)	☐ Yes ☐ No
Cancer	Sibling(s)	☐ Yes ☐ No
Cancer type(s)	Sibling(s)	

Review of Systems

Please check the appropriate response to all of the following

Constitutional
- ☐ Recent weight loss of > 10 pounds
- ☐ Recent weight gain of > 10 pounds
- ☐ Fever
- ☐ Chills
- ☐ Night sweats

Endocrine
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Cold intolerance
- ☐ Heat intolerance

Cardiac
- ☐ Angina/chest pain
- ☐ Palpitations
- ☐ High blood pressure
- ☐ Irregular pulse
- ☐ Swelling of hands or feet
- ☐ Dizziness, light-headedness, fainting

Genitourinary
- ☐ Urinary tract infections
- ☐ Blood in urine
- ☐ Increase in frequency of urination
- ☐ Urinary hesitation
- ☐ Incontinence
- ☐ Decreased libido
- ☐ Painful urination

Ear, Nose and Throat
- ☐ Ear pain/ infections
- ☐ Ear discharge
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Nose bleeds
- ☐ Nasal congestion/drainage
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficulty swallowing

Musculoskeletal
- ☐ Back pain
- ☐ Joint pain/swelling
- ☐ Shoulder pain
- ☐ Muscle cramping
- ☐ Muscle weakness
- ☐ Fibromyalgia
- ☐ Neck pain/stiffness
- ☐ Arm pain ☐ Left ☐ Right
- ☐ Leg pain ☐ Left ☐ Right

Respiratory
- ☐ Bronchitis/asthma
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Excessive cough
- ☐ Coughing up blood
- ☐ Pneumonia

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gastritis
- ☐ Ulcers
- ☐ Jaundice
- ☐ Liver disease

Skin
- ☐ Rash
- ☐ Dryness
- ☐ Itching

- ☐ Moles that changed in color/shape/size
- ☐ New moles

Hematologic/Oncologic
- ☐ Abnormal bruising
- ☐ Bleeding tendencies
- ☐ Enlarged lymph nodes
- ☐ Blood transfusion
- ☐ Blood thinning medications
- ☐ Organ donor

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Memory loss
- ☐ Paranoia
- ☐ Suicidal ideations
- ☐ Bipolar disorder
- ☐ Manic depression
- ☐ Hallucinations

Allergic/Immunologic
- ☐ Food allergy
- ☐ Environmental allergy
- ☐ Medication allergy(s)

- ☐ Latex allergy
- ☐ HIV exposure
- ☐ Autoimmune (Lupus)

Nervous System
- ☐ Headache
- ☐ Tremors
- ☐ Changes in vision
- ☐ Seizures
- ☐ Dizziness/fainting
- ☐ Change in speech
- ☐ Inability to concentrate
- ☐ Weakness ☐ arm, left / right (circle) ☐ leg, left / right (circle)
- ☐ Difficulty with balance
- ☐ Disorientation
- ☐ Loss of sensation
- ☐ Numbness and tingling ☐ arm, left / right (circle) ☐ leg, left / right (circle)

Please list any other information that may be pertinent to your care

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