

Adult Registration Forms
Please Complete **ENTIRE FORM**
Please use **BLACK Ink only.**



Patient Name: _____

Review of Systems

Have you currently or recently experienced problems with the following:

Constitutional

Circle One

Unexplained Fever	Yes	No
Weight Loss	Yes	No
Excessive Fatigue	Yes	No
Night Sweats	Yes	No

Eyes Date of Last Exam: _____

Glaucoma	Yes	No
Cataracts	Yes	No
Double or blurred vision	Yes	No

Ear, Nose, Throat and Mouth

Hearing Loss	Yes	No
Ringling In Ears <i>Circle: Left Right Both</i>	Yes	No
Balance Disturbance (e.g., Vertigo, Spinning)	Yes	No
Inability to Smell	Yes	No
Sinus Problems	Yes	No
Sore Throat	Yes	No
Mouth Sores	Yes	No

Cardiovascular Date of Last **EKG**: _____

High Blood Pressure	Yes	No
Irregular Pulse	Yes	No
Heart Murmur	Yes	No
High Cholesterol	Yes	No
Swelling in Feet or Hands	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid Disease	Yes	No
Excessive Thirst	Yes	No
Frequent Urination	Yes	No

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Respiratory

Circle One

Chronic Cough	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Bronchitis (in last 6 months)	Yes	No
Pneumonia (in last 6 months)	Yes	No
Tuberculosis	Yes	No

Integumentary

Skin Disease or Skin Cancer	Yes	No
Breast Pain, Tenderness or Nipple Discharge	Yes	No
Date of last mammogram _____		

Gastrointestinal

Indigestion	Yes	No
Pain <i>with eating</i>	Yes	No
Nausea / Vomiting	Yes	No
Abdominal Pain	Yes	No
Change in Your Bowel Habits	Yes	No

Genitourinary

Urinary Tract Infections	Yes	No
Difficulty Starting or Stopping Stream	Yes	No
Incontinence	Yes	No
Kidney Stones	Yes	No

Musculoskeletal

Broken Bones (If Yes) – Please list: _____	Yes	No
Arm Pain (If Yes – circle: Left, Right or Both)	Yes	No
Arm Weakness (If Yes – circle: Left, Right or Both)	Yes	No
Leg Pain (If Yes – circle: Left, Right or Both)	Yes	No
Leg Weakness (If Yes – circle: Left, Right or Both)	Yes	No
Back pain	Yes	No
Neck pain	Yes	No
Joint Pain (If Yes) – Please list: _____	Yes	No
Joint Swelling (If Yes) – Please list: _____	Yes	No
Arthritis (rheumatoid or degenerative)	Yes	No

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Psychiatric

Anxiety Yes No
 Depression Yes No
 Other Psychiatric Disorder/Treatment: _____ Yes No

Neurological

Headache or headache disorder* Yes No

*(If Yes – please describe: Location – Duration – Frequency – Sensitivity to Lights, Etc.)

Fainting Spells or “Blacking Out” Yes No
 Seizures Yes No
 Problems with Your Memory Yes No
 Problems with Disorientation Yes No
 Difficulty with Your Speech Yes No
 Face Weakness Yes No
 Coordination in Arm (If Yes – circle: Left, Right or Both) Yes No
 Coordination in Legs (If Yes – circle: Left, Right or Both) Yes No
 Risk for Creutzfeld-Jacob Disease (i.e., prior craniotomy with dura or
 tissue transfer, eye transplant, or growth hormone) Yes No

Hematologic/Lymphatic

Anemia Yes No
 Bleeding Tendencies/Hemophilia/Clotting disorder Yes No
 Blood Transfusion-If yes, when? _____ Yes No

Family History

<u>Family member</u>	<u>Alive</u>	<u>Deceased</u>	<u>Age</u>	<u>Health status or cause of death</u>
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

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Patient Name: _____

Family History/Social History

Occupation: _____

Marital Status: Single Married Divorced Widowed
Do you live alone? Yes No Who lives with you? _____
Do you have children? Yes No How many? _____

Do you smoke?

Yes, I've smoked _____ packs of cigarettes per day for _____ years.
 Yes, I smoke cigars or a pipe
 No, I have never smoked
 No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____ years

Do you drink alcohol? No, but I used to

Yes (If Yes) Daily 1 or more times a week 1 or more times a month
 No (If No) (never drank) No - I quit _____ years ago.

Do you have a history of narcotic drug abuse? Yes No

Are you at risk for AIDS? (e.g. sexual orientation, drug abuse, previous blood transfusion)?

Yes No IF YES, please explain: _____

The above information is accurate to the best of my knowledge.

Patient Signature

Date

I have reviewed the above information with the patient.

Physician Signature (Midwest Neurosurgery)

Date