Neurosurgical Associates
Patient Update Form

PATIENT NAME: _____ DOB: _____Ht: _____Wt: _____EMAIL: _____

1. Please list any changes to your home address, insurance or phone number(s) since your last visit. O **No Changes**

Address: _____

Phone Numbers: (H) _____**(C)** _____

Insurance: _____ **Policy #:**_____

2. Please note any **NEW** medications and/or allergies since your last visit.

MEDICATIONS: O **No Changes** **Discontinued:** **New (include dosage & frequency):**

_____ _____

_____ _____

ALLERGIES: O **No Changes** O **No Known Drug Allergies** O **New:** _____

3. Please check any **NEW** medical conditions, symptoms, surgeries and/or family history since your last office visit.

MEDICAL HISTORY: O **No Changes**

O Hypertension	O Diabetes	O Pacemaker	O Congestive Heart Failure	O Stroke
O Coronary Artery Disease	O Kidney Failure	O Heart Attack	O Elevated Cholesterol	O Cancer
				O COPD

REVIEW OF SYSTEMS: O **No Changes**

O Chest Pain	O Ringing in ears	O Sexual Dysfunction	O Loss of consciousness
O Fatigue	O Hearing Loss	O Frequent or painful urination	O Memory Loss
O Leg Swelling	O Depression	O Trouble concentrating	O Weakness
O Blurred Vision	O Anxiety	O Headache	O Vertigo
O Weight loss or gain	O Urinary Urgency or Incontinence		

SURGICAL HISTORY: O **No Changes**

O Colonoscopy	O Prostate Surgery	O Ulcer Surgery	O Knee Surgery
O Breast Cancer Surgery	O Cholecystectomy	O Appendectomy	O Weight Loss Surgery
O Heart Valve Replacement	O Bypass Surgery	O Hysterectomy	O Hip Surgery

FAMILY HISTORY: O **No Changes**

O Arthritis	O Hypertension	O Cancer	O Diabetes
O Heart Attack	O Heart Disease	O High Cholesterol	O Stroke

4. Please check the appropriate box for each **SOCIAL HISTORY** section:

Tobacco Use:	**Alcohol Consumption:**	**Drug Use:**
O current smoker	O drinks alcohol	O uses illicit drugs
O previous smoker	O does not drink alcohol	O previous drug use
O nonsmoker		O does not use drugs