Neurosurgical Associates
Patient Update Form

PATIENT NAME: _____DOB: _____Ht: _____Wt: _____EMAIL: _____

1. Please list any changes to your home address, insurance and/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 :

_____ _____

_____ _____

ALLERGIES: O **No Changes**

O No Known Drug Allergies

O New: _____

3. HPI: Patients who are following-up after injections and/or physical therapy, please complete this section.

Have you completed physical therapy since your last visit? O Yes O No O N/A

Approximately how many visits were completed? O 1- 4 visits O 5-8 visits O 9-12 visits O more than 12 O N/A

Do you feel your symptoms have decreased since starting therapy? O Yes O No change O Increased symptoms O N/A

Have you completed injections since your last visit? O Yes O No O N/A

How many injections have you had since your last visit? O 1 injection O 2 injections O 3 injections O N/A

Do you feel your symptoms have decreased since the injection(s) O Yes O No change O Increased symptoms O N/A

4. HISTORY OF PRESENT ILLNESS: ALL PATIENTS PLEASE COMPLETE THIS SECTION.

Please rate your pain on a scale of 0 to 10: O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

What symptoms are you experiencing today? O no symptoms O back pain O neck pain O numbness
O weakness O leg pain O arm pain

What makes your symptoms **better**? O sitting O standing O bending forward O bending backward O laying flat
O walking O injections O pain medication O physical therapy O nothing

What makes your symptoms **worse**? O sitting O standing O bending forward O bending backward O laying flat
O walking O injections O pain medication O physical therapy O nothing

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5. 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

6. 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