

Neurosurgical Associates at St Francis



Medical History Questionnaire for Disorders of the Head / Brain

Patient's name _____ D.O.B. _____ Age _____

What is your primary complaint that brought you here today? _____

When did you first begin to notice symptoms? _____

Describe these symptoms _____

Do you normally have headaches? Y N Where? _____

Do you have neck stiffness? Y N Does light hurt you eyes? Y N

Have you ever had head trauma, injury, or surgery Y N if yes, please explain _____

Have you noticed any problems with your vision or hearing? Y N Please describe _____

Have you has any difficulty with words, speech or walking? Y N _____ Please describe _____

Have you had any recent episodes of nausea/vomiting, loss of appetite, dizziness, or loss of balance? _____

Have you noticed any weakness of your arms or legs? Y N _____

Have there been any changes with your long or short term memory? Y N _____

Please describe _____

Any confusion or disorientation Y N _____ Please describe _____

Have you had episodes of passing out or seizures? Y N _____ Please describe _____

What testing have you had? (please check) CTA CT MRI MRA Arteriogram EEG
 Skull Films PET scan Functional MRI Neuropsychological Evaluation

Factors That May Affect Learning

Who is to be taught?: patient other; if other, relationship to patient _____

Able to read?: yes no with difficulty Comments _____ Potential

barriers to learning: none blind poor vision deaf decreased hearing unable to talk

learning disability inability to understand memory loss language, if other than English _____

Learns best by: reading verbal instruction practicing talking watching other, _____

Are there any cultural or religious beliefs that need to be considered in the care? yes no

If yes, _____

Signature _____ Relationship to patient _____ Date _____

Staff review date & initials _____