Neurosurgery
739 Irving Ave., Suite 600
Syracuse, NY 13210
315.701.2550 ● Fax 315.701.2551
www.crousemed.com

Patient Demographics and Insurance Information

Patient Name: (First MI Last) ________________________________ **Age**: _____ **DOB**: ____________

Address: ________________________________ **City**: ________________**State**: ____ **Zip**: ___________

Social Security #: __________________ _____ **Gender**: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑Divorced ❑ Widowed

Home Phone: ________________ **Cell Phone**: ________________ **Work Phone**: ________________

Email Address: ___________________________________

Preferred Method of Communication: ❑ Email ❑ Phone ❑ Mail

Caregiver Name (if applicable): _________________________ **Caregiver Ph. #:** __________________

Relationship to Pt: ______________________________

Emergency Contact Name: _______________________ **Emergency Contact Ph. #:** _________________

Relationship to Pt: ______________________________

Who referred you to us? (First and Last Name; if no one, write self)

____

Primary Care Physician (First and Last Name) ______________________________________

Phone #: _________________________

Employment Status: ❑ FT ❑ PT ❑ Student ❑Retired ❑ Other

Employer: ______________________________ **Position:** _____________________________

Employer Phone #: __________________________________

Employer Address:

____

Is this work related? ❑ No ❑ Yes If Yes, date of injury: _____________

Carrier/Claim #: _____________________________

Is this related to an auto accident? ❑ No ❑ Yes If Yes, date of injury: ______________

Carrier/Claim #: ______________________________

Primary Insurance: _____________________________ **Member ID#:** __________________________

Group #: _____________________

Policy Holder: _______________________ **Policy Holder DOB:** _______________

Relationship to Patient: __________________

Secondary Insurance: ___________________________ **Member ID#:** __________________________

Group #: ______________

Policy Holder: _______________________ **Policy Holder DOB:** _______________

Relationship to Patient: __________________

I acknowledge that I have read and will adhere to the Office Policies and Procedures of Crouse Medical Practice, PLLC Neurosurgical Office and I affirm that the above information is correct to my knowledge.

____ ________________________________

Signature of Patient or Representative **Date**

Patient History Form

Reason for Visit/Chief Complaint:

____

Past/Personal Medical History (check all that apply):

❑ Hypertension (High Blood Pressure) ❑ High Cholesterol ❑ Kidney Failure ❑ Cancer Type/Description:	❑ Diabetes ❑ Stroke ❑ Liver Failure ❑ MRSA Infection ❑ Other Chronic Conditions (*please list*):	❑ Heart Disease/Heart Attack ❑ Arthritis ❑ COPD ❑ Aneurysm ❑ Headache/Migraine ❑Sleep Apnea

Past Surgical History (please list all prior surgeries):

Surgery	Year	Surgery	Year

Have you ever had any problems/complications with anesthesia? ❑ No ❑ Yes

Family History:

Family Member	**Significant Medical Problems:**	**Alive or Deceased:**	**Age (or age at death):**
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			
Mother			
Father			
Siblings			
Other (uncles, aunts, etc.)			

Patient Name: ______________________________ **DOB:** _______________

Medications (please list all current medications, including vitamins):

Name of Medication	Dose	Frequency

Allergies (please list all drug allergies):

Drug	Reaction

Social History:

Drinks Alcohol	Do you currently drink alcohol? ❑ No ❑ Yes If yes, how often? Please circle: Daily – Weekly – Monthly – Socially – Rarely ❑ Beer ❑ Wine ❑ Liquor Amount? When was your last drink? Do you have a history of alcohol use/abuse? ❑ No ❑ Yes If yes, how often? How much?
Tobacco Use	Do you currently smoke? ❑ No ❑ Yes If yes, how many packs per day? How long have you been smoking? Were you a previous smoker and have quit? ❑ No ❑ Yes What year did you quit? How long did you smoke for?

Drug Use	Do you currently use recreational drugs? ❑ No ❑ Yes Have you in the past? ❑ No ❑ Yes
	Have you ever used intravenous drugs? ❑ No ❑ Yes
Caffeine Use	If yes, what kind? Please circle: Coffee – Soda – Chocolate – Tea – Other: ______________________________
	How many cups? How many sodas?
Employment	Occupation (past and present):
Living Arrangements	Marital Status: ❑ Single ❑ Married ❑Divorced ❑ Widowed Who lives in your home with you? ____ Do you have children? ❑ No ❑ Yes If yes, how many?

Hand Dominance: ❑ Left-handed ❑ Right-handed

Have you had Physical Therapy? ❑ No ❑ Yes Dates: ____

How many visits? ________________

Have you had Pain Management? ❑ No ❑ Yes Dates: ____

How many visits? ________________

Type of Pain Management Treatment administered?: ____

Have you had Chiropractic Treatment? ❑ No ❑ Yes Dates: ____

How many visits? ________________

____ ______________________________

Provider Signature **Date**

Please check whether you have any of the following problems, either CURRENTLY or REPEATEDLY:

Constitutional		
Fever	❑ Yes	❑ No
Headache	❑ Yes	❑ No
Unexplained Weight Loss	❑ Yes	❑ No
Other:		

Neurologic/Psychiatric		
Numbness	❑ Yes	❑ No
Tingling	❑ Yes	❑ No
Weakness	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No
Memory Loss	❑ Yes	❑ No
Seizures	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No
Spinal Cord Injury	❑ Yes	❑ No
Headache	❑ Yes	❑ No
Other:		

Respiratory		
Shortness of Breath	❑ Yes	❑ No
Wheezing	❑ Yes	❑ No
Cough	❑ Yes	❑ No
Other:		

Cardiovascular		
Chest Pain	❑ Yes	❑ No
Irregular Pulse	❑ Yes	❑ No
Heart Attack	❑ Yes	❑ No
Heart Valve Problem	❑ Yes	❑ No
Other:		

Gastrointestinal		
Abdominal Pain	❑ Yes	❑ No
Nausea/Vomiting	❑ Yes	❑ No
Indigestion/Heartburn	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No
Constipation	❑ Yes	❑ No
Other:		

ENT		
Runny Nose	❑ Yes	❑ No
Difficulty Hearing	❑ Yes	❑ No
Other:		

Metabolic/Endocrine		
Excessive Thirst	❑ Yes	❑ No
Too Hot	❑ Yes	❑ No
Too Cold	❑ Yes	❑ No
Other:		

Immunologic		
Hay Fever	❑ Yes	❑ No
Food Allergies	❑ Yes	❑ No
Other:		

Musculoskeletal		
Joint Pain	❑ Yes	❑ No
Back Pain	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No
Other:		

Hematologic		
Easy Bruising or Bleeding	❑ Yes	❑ No
Blood Clot in arms or legs	❑ Yes	❑ No
Anemia	❑ Yes	❑ No
Other:		

Genitourinary		
Back Pain	❑ Yes	❑ No
Cloudy Urine	❑ Yes	❑ No
Nausea	❑ Yes	❑ No
Other:		

Vascular		
Cool Extremity	❑ Yes	❑ No
Pain in Limb	❑ Yes	❑ No
Varicose Veins	❑ Yes	❑ No
Other:		

Dermatologic		
Rash	❑ Yes	❑ No
Boils/Infections	❑ Yes	❑ No
Other:		