Temecula Valley Neurosurgery, Inc.
25150 Hancock Avenue, Suite 210
Murrieta, Ca 92562

Phone: 951-587-3739
Fax: 951-698-5213

Past Medical History

Patient Name: _____ Date of Birth: _____Date:_____
Reason for Visit: _____ **PCP:** _____

☐ **No Medical Diagnosis**

Check the condition(s) that apply to your past medical history -

- ☐ Anemia
- ☐ Anesthesia problem
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Back Problems
- ☐ Bladder Infections
- ☐ Bleeding Disorder
- ☐ Blood Clots / CVT
- ☐ Blood Transfusions
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Congestive Heart Failure
- ☐ COPD / Emphysema
- ☐ Crohns / Ulcerative Colitis
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Epilepsy / Seizures
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Burn
- ☐ Heart Disease / CAD
- ☐ Heart Murmur
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/ AIDS
- ☐ Hyperthyroid / Hypothyroid
- ☐ Insomnia
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease/ Cirrhosis
- ☐ Lung Disorder
- ☐ Lupus
- ☐ Malaria
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Mumps
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pancreatitis
- ☐ Parkinson's
- ☐ Peripheral Vascular Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seasonally Allergies
- ☐ Sexually Transmitted Diseases
- ☐ Shingles
- ☐ Sleep Apnea
- ☐ Smallpox
- ☐ Stroke / TIA
- ☐ Tuberculosis
- ☐ Urinary Incontinence
- ☐ Vertigo
- ☐ Whooping Cough

Smoking Status:

- ☐ Current smoker — If yes, Packs/day:____ Number of Years:____
- ☐ Former smoker — Quit Date: ___/___/_____
- ☐ Never smoker

Alcohol Use Status:

- ☐ Does not drink
- ☐ Currently drinks — If yes, Alcohol Type:_____ Drinks/Week:_____
- ☐ Former drinker — Quit: ___/___/_____
- ☐ Quit

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Illicit/Illegal drugs Status:

- ☐ Does not take drugs
- ☐ Currently takes drugs If yes, Drug Type:_____
- ☐ Former drug user
- ☐ Quit Quit: ___/___/_____

Injury Information/ Type of Injury: Related to current symptoms

- ☐ Work If yes, Injury Date: ___/___/_____ Injury Details:_____
- ☐ Auto
- ☐ Sports
- ☐ Other

Family Medical History

Check the condition(s) that apply and indicate which family member:

Condition:	Relationship to patient: eg. Mother, Father, Sister, son
☐ Anemia	_____
☐ Arthritis	_____
☐ Asthma	_____
☐ Blood Clots/DVT	_____
☐ Cancer	_____
☐ COPD/Lung Disease	_____
☐ Depression	_____
☐ Diabetes	_____
☐ Heart Disease/CAD	_____
☐ Hepatitis	_____
☐ High Blood Pressure	_____
☐ HIV/AIDS	_____
☐ High Cholesterol	_____
☐ Irregular Heartbeat	_____
☐ Liver Disease	_____
☐ Osteoporosis	_____
☐ Prostate	_____
☐ Stomach Ulcer/Reflux	_____
☐ Stroke/Seizures	_____
☐ Vascular Disease	_____
☐ Thyroid Disease	_____
Other:_____	_____

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Patient Name:_____ **DOB**:_____

Past Surgeries

Surgery/Procedure	Hospital	Date	Comments

Current Prescriptions and Over-the-counter Medications

Drug name	Dosage	Drug name	Dosage

Do you take aspirin or anti-inflammatory medications? **No** **Yes- Please list below**

What is your preferred pharmacy?_____

Do you take any of the following medications? **Plavix** **Coumadin** **Warfarin** **Pradaxa** **Xeralto**

Patient Drug Allergies

☐ **No known drug Allergies.**

Allergy	Severity (Mild, Moderate, Severe)	Date	Comments

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