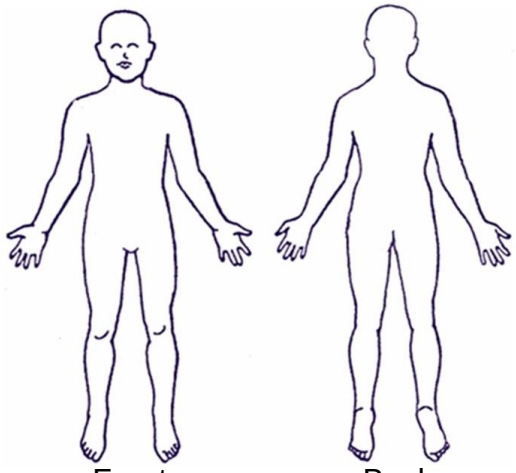
NEUROSURGERY: NEW PATIENT (DR. THAI)

REFERRING DOCTOR:_____ FAMILY DOCTOR:_____
PREVIOUS NEUROSURGEON/SURGEON (IF ANY): _____

NAME: _____DATE OF BIRTH:_____AGE:_____
RIGHT OR LEFT HANDED: _____ GENDER: M or F WEIGHT _____ HEIGHT_____
CURRENT/FORMER OCCUPATION: _____ STILL WORKING? _____
PRIMARY PROBLEM: _____
WHAT DATE IT STARTED: _____ IS IT CONTINUOUS or INTERMITTENT?_____
HOW IT HAPPENED:_____
IT IS GETTING Better / Worse / Same (circle one) DO YOU HAVE WEAKNESS? _____
WHAT MAKES IT BETTER:_____ WHAT MAKES IT WORSE:_____
HOW BAD IS IT NOW (Scale of 0-10):_____ IS IT Burning/Sharp/Dull/Numb/Tingling?

Please shade the area where you have pain



PREVIOUS MEDICAL HISTORY:

PREVIOUS SURGERIES (and date):

ALLERGIES: _____

CURRENT MEDICINE NAME	DOSE/STRENGTH	HOW OFTEN	LAST TAKEN

BACK/SECOND PAGE to complete Questionnaire ==========➔

Quoc-Anh Thai, MD, FAANS, FACS

Are you currently or do you regularly experience: ***(Please check all that apply)***

Constitutional	☐ Weight Loss	☐ Fatigue	☐ Fever
Eyes	☐ Blurred vision	☐ Double vision	☐ Eye pain
Ears, Nose Throat & Mouth	☐ Headaches ☐ Ringing in ears ☐ Pressure sensation in ear ☐ Ear pain ☐ Nasal Obstruction ☐ Nose bleeding ☐ Purulent nasal discharge ☐ Sore throat ☐ Change in voice ☐ Neck tenderness	☐ Vertigo/dizziness ☐ Roaring sound in ears ☐ Itching in ear ☐ Nasal pain ☐ Sinus pain ☐ Nasal discharge ☐ Mouth pain ☐ Snoring ☐ Frequent throat clearing ☐ Dentures	☐ Hearing loss ☐ Ear fullness ☐ Ear discharge ☐ Decreased sense of smell ☐ Nasal congestion ☐ Postnasal drip ☐ Swollen glands ☐ Hoarseness ☐ Difficulty swallowing ☐ Lump sensation in throat
Cardiovascular	☐ Chest pain	☐ Hypertension	☐ Palpations
Respiratory (Lungs)	☐ Shortness of breath ☐ Coughing blood	☐ Wheezing	☐ Cough
Gastrointestional (Stomach)	☐ Nausea ☐ Painful Swallowing	☐ Vomiting ☐ Excessive belching	☐ Difficulty swallowing ☐ Heartburn/Acid reflux
Genitourinary	☐ Urgency ☐ Incontinence	☐ Frequency ☐ Difficulty starting urine stream	☐ Pain when urinating ☐ Numbness between legs
Integumentary (Skin)	☐ New skin lesions	☐ Pigmentation changes	☐ Changes to existing skin lesions
Neurological (Nerves)	☐ Tremors ☐ Tingling or numbness	☐ Seizures	☐ Loss of balance
Musculoskeletal	☐ Joint pain	☐ Joint swelling	☐ Muscle pain
Endocrine	☐ Cold intolerance ☐ Weight loss	☐ Heat intolerance ☐ Weight gain	☐ Loss of hair ☐ Hot flashes
Psychiatric	☐ Anxiety	☐ Depression	☐ Difficulty sleeping
Hematologic/Lymph Nodes	☐ Easy bleeding	☐ Easy bruising	☐ Lymph node enlargement or tenderness
Allergic/Immunologic	☐ Reaction to anesthesia	☐ Sneezing	☐ Itchy watery burning eyes

DO YOU FAMILY HISTORY OF SAME ILLNESS? _____
SINGLE or MARRIED? DO YOU SMOKE: Y N HOW MANY PACKS PER DAY_____
ANY NON-PRESCRIBED DRUG DEPENDENCY? Y N _____
HOW MUCH ALCOHOL DO YOU USE? _____
ARE YOU TAKING ASPIRIN, COUMADIN, PLAVIX, or other blood thinners?

<u>You MUST bring the following with you for your first neurosurgery office visit with Dr. Thai:</u>

1. **Dr. Thai's New Patient form (this form, completely filled out, signed, and dated)**
2. **CT/MRI report. Imaging Facility and Date of your Report: _____**
3. **CD ROM of your CT/MRI.**
4. Also bring any other related information, if you have them (EMG/NCV, Referral letter, etc).

PATIENT SIGNATURE:_____ DATE:_____

----------Office Use Only Below Here----------