## Joseph A. Shehadi, M.D., FRCSC, FAANS Northtowns Neurosurgery PLLC

## Initial Medical History Form (Please Print)

Name:		Age				
Which hand do you write with						
Have you ever seen Dr. Joseph Shehadi before'						
Referring Physician						
Address						
Family Physician						
Address						
Other physicians you have seen for this proble						
Address	AddressPhone					
How did you first hear about us? Please circle	only one:					
Referring doctor	Google reviews	LinkedIn				
Word of mouth	Healthgrades	Other:				
Practice website	Facebook					
REASONS FOR THIS OFFICE VISIT						
(Please check <b>ALL</b> that apply)						
	Pain: Where, exactly, is your pain?					
How severe is the pain? (On a scale of 1-10):						
How long have you had this pain?						
What makes the pain better? (Chec	k all that apply)					
□ Pain pills □ Rest □ lea	nning forward □ Other					
What makes the pain worse? (Chec	k all that apply):					
<ul><li>□ physical activity</li><li>□ prolonged sittir</li><li>□ coughing</li><li>□ sneezing</li></ul>	ng □ prolonged standing □ other					
Numbness (decreased feeling): Where is your numbness?						
Weakness (loss of muscle power): Where is your weakness?						

□ Urine incontinence (accidents) □ Bowel incontinence □ Constipation					
□ Sexual Dysfunction					
What <b>conservative treatment</b> measures have you had for this problem? (check all that apply):					
□ Medications □ Steroid injections □ Physical Therapy □ Chiropractic care □ TENS unit					
Other					
What Surgical Treatments (if any) have you had for this problem?					
PAST MEDICAL HISTORY (e.g. diabetes, etc)					
	$\exists$				
	=				
CURRENT MEDICATIONS/SUPPLEMENTS Dose Frequency					
Pharmacy Phone					
Do you currently take <b>aspirin</b> or products containing <b>aspirin</b> ?   □ Yes  □ No					
ALLERGIES (to any medications, food, or contrast dye)					
PAST SURGERIES/HOSPITALIZATION Year Doctor Complications	<u> </u>				

## **FAMILY MEDICAL HISTORY**

Family Member Mother	Alive	Deceased	Age	Health Status or Cause of Death		
Father						
SOCIAL HISTOR	<u>Y</u>					
Occupation				<del></del>		
Are you currently wor	king? □ Y	□ N If not work	ing, when w	vas the last day you worked?		
Tobacco: ☐ Yes, I smoke ☐ No, I have n ☐ No, I quit	ever smoked	d cigarettes.	per day and	d have for the past years.		
Alcohol: How many	alcoholic be	everages do you	consume p	er <b>week</b> ?		
Are you at risk for AIDS (e.g. previous blood transfusion, drug abuse, sexual history)						
□ Yes □ No	If yes, plea	ase explain				
	ave a pacen  MPTOMS	naker or any met	al implantat	that has not already been described? ions, rare blood disorders, Jehovah's Witness		
Constitutional		Genit	ourinary			
☐ Fever			☐ Urinary Trac	et Infection		
Weight Loss			Painful urina			
☐ Excessive Fatigue	•		Blood in you			
☐ Night Sweats				arting/stopping stream		
☐ Loss of Appetite	Mandh		Incontinence			
Eyes, Ear, Nose, Throat, Hearing Loss	Mouth		☐ Kidney Ston☐ Prostate Can			
☐ Wear a Hearing A	id		Endometrios			
☐ Ringing in Ears				dervical Cancer (female)		
☐ Eye Infections			uloskeletal			
Eye Injuries			☐ Broken Bon	es, List		
☐ Glaucoma			Arm or leg v	veakness		
Cataracts			■ Back pain			
☐ Ear Pain			Arm or Leg			
☐ Ear Infections			Joint pain or	swelling		
☐ Sore Throats		L	☐ Arthritis			
<ul><li>Mouth Sores</li><li>Balance Disturbate</li></ul>	noa (vartigo/s=:	nning) Inton	ımontowy			
☐ Lightheadedness	ice (verugo/spi		ımentary ☑ Skin Cancer			
☐ Nosebleeds			Breast pain			
☐ Nasal Congestion		_	tenderness/sw	velling		
☐ Nasal Drainage			☐ Nipple disch			
If yes, color	amount			lt of last mammogram		

☐ Inability to smell	Neurological
☐ Sinus Problems	☐ Fainting Spells
☐ Sinus Headaches	☐ Seizures
	☐ Problems with your memory
	☐ Disorientation
Cardiovascular	☐ Difficulty with your speech
☐ Chest Pain or Angina	☐ Inability to concentrate
If yes, date of last EKG	
☐ Palpitations	☐ Face weakness
☐ Irregular Pulse	☐ Lack of coordination in arms/legs
☐ Heart Murmur	Ç
☐ High Cholesterol	
Respiratory	Psychiatric
☐ Asthma	□ Depression
☐ Chronic Cough	☐ Anxiety
☐ Emphysema	☐ Other psychiatric disorders/treatments
☐ Shortness of Breath	Endocrine
☐ Bronchitis	☐ Diabetes
☐ Pneumonia	☐ Thyroid disease
☐ Lung Cancer	☐ Increased appetite
☐ Bloody Sputum	☐ Excessive thirst or urination
if yes, date of last	☐ Hormone problems
☐ Chest x-ray	Hematologic/Lymphatic
Gastro-Intestinal	☐ Anemia
Indigestion or pain with eating	☐ Hemophilia
☐ Trouble swallowing	☐ Bleeding tendencies
☐ Nausea	☐ Persistent swollen glands/lymph nodes
☐ Vomiting	If yes, when
☐ Blood in your vomit	☐ Blood transfusion
☐ Liver problems	Allergic/Immunologic
☐ Jaundice	☐ Food allergies
☐ Abdominal Pain	If yes, list
☐ Change in your bowel habits	If yes, list ☐ Inhalant (nasal allergies)
☐ Ulcers or Gastritis	☐ Immunologic disorders
All the information provided above is acc	urate and complete to the best of my knowledge.
Patient Signature	
I have reviewed the above information w	ith the patient.
Physicians Signature	

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