Anchorage Neurosurgical
ASSOCIATES INC.
BRAIN | SPINE | NERVES | EST. 1981

HISTORY SHEET

Name: _____ Age: _____ Referring Doctor: _____

Drug Allergies: ☐ Yes ☐ No ☐ Tetanus ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Morphine ☐ Demerol ☐ Aspirin
Please list any other drug allergies: _____

Medical History:
Have you ever been hospitalized? ☐ Yes ☐ No How many times? _____
Have you had any operations? ☐ Yes ☐ No If so, what for? _____

_____

Are you on medication today? ☐ Yes ☐ No If Yes, please complete the Medication Sheet.
Are you currently taking: ☐ Aspirin ☐ Vitamins ☐ St. John's Wort ☐ Other OTC medications: _____
Have you ever been under Pain Management? ☐ Yes ☐ No Have you ever signed a pain contract? ☐ Yes ☐ No

Diagnostic Studies: Any of the following diagnostic studies completed?
☐ X-rays ☐ CT ☐ MRI ☐ EMG ☐ Myelogram ☐ Discogram ☐ Epidural Steroid Injection ☐ Bone Scan

Have you tried?
☐ Bed Rest ☐ Physical Therapy ☐ Other Medical Treatments: _____
☐ Medications ☐ Chiropractic Manipulation ☐ Alternative Treatments: _____

Describe your symptoms related to why you are being seen?
☐ Aching ☐ Burning ☐ Stabbing ☐ Shooting ☐ Sharp ☐ Dull ☐ Headache ☐ Other: _____

Have you had any disease associated with the following?
☐ Lungs ☐ Heart ☐ Liver ☐ Kidney ☐ Diabetes ☐ Tuberculosis ☐ Cancer ☐ Convulsions
If so, please explain: _____

List contagious disease contracted: _____

Any head injuries? ☐ Yes ☐ No Injury(ies) & Year(s): _____
Any fractures? ☐ Yes ☐ No Injury Site(s) & Year(s): _____
Bleeding tendency: ☐ Yes ☐ No _____
Blood transfusion? ☐ Yes ☐ No How many? _____ Year: _____ Reason: _____

Family History	Age	Health (be specific)	If deceased, age & cause of death
Mother			
Father			
Siblings			
Children			

Social History: Do you? Smoke ☐ Yes ☐ No How much? _____ How many years? _____
Drink ☐ Yes ☐ No How much? _____ How many years? _____
Have you ever been addicted to Drugs or Alcohol? ☐ Yes ☐ No

Are you: ☐ Right Handed ☐ Left Handed

_____ _____
Signature of Patient, Parent, Guardian, Personal or Legal Representative Date