neurotexas®
Brain & Spinal Surgery

Name: _____ **Date:** _____

DOB: _____ **Height:** _____ **Weight:** _____

1. **Has any of your <u>contact information</u> or <u>insurance</u> changed?** Yes / No
   (If yes, please provide new info to receptionist)

Send Visit Note to Provider?

2. **Referring Physician:** _____ ☐
3. **Primary Care Physician:** _____ ☐
4. **Pain Management Physician:** _____ ☐

5. **Is this a post-operative visit (within 90 days of surgery)?** Yes / No
6. **If yes, date of surgery:** _____

7. **Purpose of today's visit/chief complaint?**
   _____

8. **Any changes since your last visit?**
   _____

9. **On a scale of 1-10, how bad is your pain today?** _____
10. **Have you had any of the following since your last visit?**
    - ☐ Physical Therapy
    - ☐ Pain Injections
    - ☐ Ibuprofen/Aspirin
    - ☐ Prescription Painkillers
    - ☐ Muscle Relaxants
    - ☐ Oral Steroids
    - ☐ Changes in Medication (please list): _____
    - ☐ Other: _____

11. **Have you had any tests or imaging since your last visit? (Circle all that apply)**

    X-Ray MRI CT Scan Myelogram EMG Discogram (Other)

12. **Where was this done?** _____

13. **Tobacco Use:** Yes / No Frequency: _____
14. **Alcohol Use:** Yes / No Frequency: _____
15. **Allergies:** Yes / No _____

16. **Do you have an Advanced Care Plan (i.e. Will, Medical Power of Attorney)?** Yes / No
17. **If yes, who is named to make decisions on your behalf if the need should arise?** _____

18. **Have you received a flu vaccine this season/year?** Yes / No
19. **Have you received a pneumonia vaccine this season/year?** Yes / No