BaylorScott&White
NEURO ONCOLOGY ASSOCIATES
DALLAS
A member of HealthTexas Provider Network

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Today's Date: _____

Patient Name: _____ Age:_____ Date of Birth:_____

Main Reason for Visit: _____

Name of person(s) attending visit with you:_____

Height: _____Weight: _____ Right Handed or Left Handed

Referring Physician_____Phone #_____City: _____

Primary Care
Physician:_____Phone#_____ _____City:_____

Other physicians involved in your care:

Physician Name:_____ Phone #_____ City: _____

Physician Name:_____ Phone #_____ City: _____

Physician Name:_____ Phone #_____ City: _____

When was your last MRI? _____ Where was the MRI performed? _____

Allergies to Medications (describe type of reaction or side effect):
_____
_____

PAST MEDICAL HISTORY: (Please circle Y or N)

Y / N High blood pressure
Y / N Diabetes
Y / N High Cholesterol/Lipids
Y / N Thyroid Disease
Y / N Heart Disease
Y / N Cancer, Tumor, Malignancy
Y / N Stroke or TIA
Y / N Diagnosis of Epilepsy or Seizures
Y / N Treatment by Psychiatrist or Counselor
Other: _____

PAST SURGERY: (Please circle Y or N)

Y / N Brain surgery: (date) _____
Tumor type (pathology):
Y / N Neck or back surgery (circle)
Y / N Vascular surgery
Y / N Heart or lung surgery (circle)
Y / N Abdominal surgery
Y / N Hysterectomy, tubal ligation, C-section (circle)
Y / N Sinus, facial or dental surgery (circle)

INJURIES: (Please circle Y or N)

Y / N Head injury
Y / N Other injuries, fractures: _____
Y / N Hand, leg, arm or foot injury (circle)
Y / N Spinal injury

Current Medications (Drug)	**Dose**	**Frequency (times taken per day)**

FAMILY MEDICAL HISTORY:

Family Member	**Check Box if Alive**	**Age (Current or at Time of Death)**	**Health Status or Cause of Death**
Grandmother (Mom's)			
Grandfather (Mom's)			
Grandmother (Dad's)			
Grandfather (Dad's)			
Mother			
Father			
Sister/Brother (circle one)			
Sister/Brother (circle one)			

Is there a history of the following in your family? (Please circle Y or N) If so, please list family member(s).

Y / N Heart Disease _____

Y / N Hypertension _____

Y / N Diabetes _____

Y / N Stroke _____

Y / N Migraine Headaches _____

Y / N Cancer (type)_____

Y / N Brain Tumor _____

Y / N Dementia_____

Y / N Multiple Sclerosis _____

Y / N Epilepsy (seizures) _____

Y / N Tremors _____

Y / N Neurofibromatosis _____

OTHER HISTORY:

Occupation: _____ Retired (year): _____

Work Status: ____Full-time ____Part-time ____ Unemployed ____Disabled: Short-term/Long-term (circle)

Marital Status: ____Single ____Married ____Divorced ____Widowed

Do you have children? ____No ____Yes How many? _____

Who lives with you at home? _____

Tobacco Use: ____ Cigarette: Packs per day _____ _____ Pipe ____ Snuff ____Cigar _____Chew

Start (year, if applicable): _____ Quit (year, if applicable): _____

Do you drink alcohol? _____ No _____ Yes How much? _____

Do you exercise regularly? _____ No _____ Yes Times per week: _____ Type: _____

Have you been exposed to HIV? _____ Unknown_____ No_____ Yes

Have you ever received a blood transfusion? _____No _____Yes Date of transfusion: _____

Have you been exposed to toxins? _____Unknown _____ No _____ Yes Type: _____