Grand River Specialty Clinic
Dr. Lee Krauth, MD – Neurosurgery

Patient Name: ______________________________ **Date of Birth:** ________________

Name of Primary Care Physician: ______________________________ **Tele #:** ________________

Address: ____________________ **City:** ____________ **State:** _____ **Zip:** ________

Name of Referring Physician: ______________________________ **Tele#:** ________________

Address: ____________________ **City:** ____________ **State:** _____ **Zip:** ________

Chief Complaint

What is the main reason for your visit today? (Describe your problem in detail)

____

____

History of Present Illness. Please describe in detail the following elements regarding your symptom(s)

Date of Onset ______________________________

Location ______________________________

Severity ______________________________

Duration ______________________________

Aggravating Factors ______________________________

Relieving Factors ______________________________

Previous Test/Evaluation ______________________________

Previous Treatment ______________________________

Previous Medical Opinions ______________________________

Other Comments ______________________________

Pharmacy Preference: ____________________ **City:** ____________ **Tele #:** ____________

Are you taking ANY kind of medication now? (including prescription, over the counter or herbal medication)

☐ No ☐ Yes If yes, please list all medications below. Please print neatly

Name, dose and how often	Problem being treated	Date of Prescription	Prescribing Doctor

Are you allergic to ANY medication: ☐ No ☐ Yes If yes, please list below.

Name of Medication	Type of Reaction

Non-Medication Allergies

Are you allergic to any non-medical thing such as pollens, dust, food, etc.? ☐ No ☐ Yes

If yes, please indicate what you are allergic to and reaction: ____________________

Past Health

Have you ever been DIAGNOSED with any major health problem? Including but not limited to:

Cancer (type) ☐ No ☐ Yes If yes, when ________

Nose and Sinus:

Nasal Allergies ☐ No ☐ Yes If yes, when ________

Heart and Blood Vessels:

Elevated Cholesterol ☐ No ☐ Yes If yes, when ________

Heart Attack ☐ No ☐ Yes If yes, when ________

High Blood Pressure ☐ No ☐ Yes If yes, when ________

Lungs and Respiratory:

Tuberculosis ☐ No ☐ Yes If yes, when ________

Stomach and Digestive:

Ulcer ☐ No ☐ Yes If yes, when ________

Stomach or Rectal Bleeding ☐ No ☐ Yes If yes, when ________

Kidney and Gender Problems:

Renal Failure ☐ No ☐ Yes If yes, when ________

Prostate Enlargement ☐ No ☐ Yes If yes, when ________

Are you Pregnant ☐ No ☐ Yes

Mental and Emotional:

Depression ☐ No ☐ Yes If yes, when ________

Anxiety ☐ No ☐ Yes If yes, when ________

Glands, Hormones and Sugar Control:

Diabetes ☐ No ☐ Yes If yes, when ________

Thyroid deficiency ☐ No ☐ Yes If yes, when ________

Thyroid excess ☐ No ☐ Yes If yes, when ________

Immune and Infectious Problems:

HIV ☐ No ☐ Yes If yes, when ________

Infectious Mono ☐ No ☐ Yes If yes, when ________

Hepatitis ☐ No ☐ Yes If yes, when ________

Blood and Lymph Node Problems:

Anemia ☐ No ☐ Yes If yes, when ________

Neurological Problems:

Stroke ☐ No ☐ Yes If yes, when ________

Seizure ☐ No ☐ Yes If yes, when ________

Eyes:

Cataracts ☐ No ☐ Yes If yes, when ________

Glaucoma ☐ No ☐ Yes If yes, when ________

Peripheral Vision Probs ☐ No ☐ Yes If yes, when _____

Have you ever been DIAGNOSED with any other major health problem not listen above? ☐ No ☐ Yes

If yes please list diagnosis and year the diagnosis was made: ____________________

Surgeries and Hospitalizations

Have you been hospitalized for a medical problem before? ☐ No ☐ Yes

If yes, list the hospitals, the reasons and the dates: ____________________

Have you ever had surgery? ☐ No ☐ Yes

If yes, list any surgeries and when they were done: ____________________

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ No ☐ Yes

If yes, please list what sort of problems: ____________________

Serious Injuries

Have you ever had a serious injury such as head, neck, back or other injury? ☐ No ☐ Yes

If yes, list and describe the type of injury and when it occurred: ____________________

____

Social History

Occupation: ____________________ Retired? ☐ No ☐ Yes Marital Status: ____________________

Right Handed? ☐ Left Handed? ☐ Do you have a living will? ☐ No ☐ Yes

Do you smoke? ☐ No ☐ Yes If yes, how much and what type of tobacco? ____________________

Do you drink alcohol? ☐ No ☐ Yes If yes, what type, how many a day/week, how often? ____________________

Do you drink caffeine? ☐ No ☐ Yes If yes how much? ____________________

How often do you exercise? ☐ None ☐ 1 – 2 times week ☐ 3 or more times a week ☐ Other: ____________________

Living Setting: ☐ **Alone** ☐ **Spouse** ☐ **Children** ☐ **Mother** ☐ **Father** ☐ **Nursing Home** ☐ **Assisted Living** ☐ **Other:** ________________

Family History

Ears:

Hearing loss before age 20	☐ Mother	☐ Father	☐ Sibling
Hearing loss after age 20	☐ Mother	☐ Father	☐ Sibling

Heart and Blood Vessels:

Heart Disease	☐ Mother	☐ Father	☐ Sibling
High Blood Pressure	☐ Mother	☐ Father	☐ Sibling

Lungs and Respiratory:

Lung Cancer	☐ Mother	☐ Father	☐ Sibling
Asthma	☐ Mother	☐ Father	☐ Sibling

Specific Anesthesia Problem	☐ Mother	☐ Father	☐ Sibling

Skin and/or Breast:

Breast Cancer	☐ Mother	☐ Father	☐ Sibling
Skin Cancer	☐ Mother	☐ Father	☐ Sibling

Brain and Nervous:

Dementia	☐ Mother	☐ Father	☐ Sibling
Neurotube Disease	☐ Mother	☐ Father	☐ Sibling
Stroke	☐ Mother	☐ Father	☐ Sibling

Blood and Lymph Node Problems:

Bleeding/Clotting Prob	☐ Mother	☐ Father	☐ Sibling
Other: ____________	☐ Mother	☐ Father	☐ Sibling

Review of Systems

Do you now or have you had any problems related to the following systems? **Circle YES or NO.**
Please explain any **YES** answers in the space provided.

Constitutional Symptoms

Fatigue	Y	N
Fever	Y	N
Weight Loss/Gain	Y	N
Other: ________________		

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other: ________________		

Allergic/Immun System

Hives	Y	N
Frequent Colds	Y	N
Unusual Infections	Y	N
Other: ________________		

Brain and Nervous System

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Other: ________________		

Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N
Other: ________________		

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Other: ________________		

Heart and Blood Vessels

Chest Pain	Y	N
Irregular Heart Beat	Y	N
Shortness of Breath	Y	N
Other: ________________		

Skin and Breasts

Skin Rash	Y	N
Boils	Y	N
Skin or Breast Lumps	Y	N
Other: ________________		

Bones, Joints, Muscles

Joint Pain	Y	N
Cramping	Y	N
Weakness	Y	N
Other: ________________		

Ear/Nose/Throat/Mouth

Hearing Loss	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other: ________________		

Kidney, Bladder or Sexual Health

Urine Retention	Y	N
Painful Urination	Y	N
Abnormal Periods	Y	N
Other: ________________		

Lungs and Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Other: ________________		

Blood and Lymph Nodes

Swollen Glands	Y	N
Blood Clotting Prob	Y	N
Prior Transfusion	Y	N
Other: ________________		

Psychological

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other: ________________		