NEUROSURGERY
ROBERT G.R. LANG MD INC. PS
3525 ENSIGN ROAD NE, SUITE J
OLYMPIA, WASHINGTON 98506
(360)491-0459
www.DrRobertLang.com

New Patient History Form

Today's Date: ____________________________________

Patient's Name: ____________________________________ How did you hear about us? ________________________

Social Security Number: ______________________________ Date of Birth: ____________________________________

Allergies R or L handed: ___________________________________

Do you have any known drug allergies? ☐ No ☐ Yes - Please list: ____

What is your preferred Pharmacy?: ____

Current Medications

Medication	Dosage	No. of Tablets	Times Per Day	What is it prescribed for?
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Present Health Conditions or Injuries

1. What is the reason for your visit today? ____

2. What symptoms are you currently experiencing? ____

____

3. How long do the symptoms last? _______________ How often do they occur? ________________________________

4. How severe are the symptoms on a scale of 0(no pain) – 10(worst imaginable)? _______________________________

5. Does anything make the problem better? ☐ Yes ☐ No Explain: ____

6. Does anything make the problem worse? ☐ Yes ☐ No Explain: ____

7. Have you had treatment for this problem?

____

Medical Symptoms

Please mark the medical condition(s) below which apply to you either now or in the past.

General

___Feel tired quickly
___Fever
___ weight concerns
___Trouble concentrating
___Chills
___Difficulty sleeping
___Night sweats
___Numerous fears
___Increased tension
___Nervousness
___Feelings of worthlessness
___Sometimes wishing you were dead
___Suicidal thoughts

Skin, Eyes, Ears, Nose, and Throat

___Frequent headaches
___Head or room spins
___Lightheadedness
___Fainting spells
___Change in taste
___Teeth/gum problems
___Hoarse voice
___Frequent sore throats
___Face swelling
___Skin problems
___Changes in moles
___Pain in ears
___Hard of hearing
___Discharge from ears
___Eye pain
___Light hurts your eyes
___Double vision
___Blurred vision
___Frequent sinus trouble
___Frequent nose bleeds

Chest and Cardiovascular

___Chronic cough
___Cough up blood
___Often sleep on pillows to breathe easier
___Wheezing spells
___Short of breath with exercise
___Wake up short of breath
___Chest pain or tightness
___swollen feet/ankles
___Phlebitis in legs
___leg cramps at night
___leg cramps when walking
___Fingers turn blue in cold
___Anemia
___Varicose veins
___Rheumatic fever
___Heart race or skip a beat
___High blood pressure
___Heart murmur
___Exposed to tuberculosis
___Sleep Apnea

Gastrointestinal

___Recent change in bowels
___Clay colored stool
___Constipation
___Indigestion
___Diarrhea
___Bowel movement black, tarry or bloody
___Loss of bowel control
___Hemorrhoids
___Polyps
___Hepatitis
___Abdominal pain
___Ulcers
___Gallstones
___Liver Disease
___Ever vomit blood
___Severe Heartburn

Musculoskeletal and Neurologic

___Stiff, painful joints
___Swollen joints
___Weakness
___Arthritis
___Osteoporosis
___Frequent falls
___Coordination problems
___Balance problems
___Trouble walking
___Numbness
___Paralysis
___Tremors
___Seizures
___Stroke
___unusual head/neck tension
___Difficulty speaking
___Loss of memory
___Blackouts
___Confusion
___Fibromyalgia

Genitourinary

___Frequency of urination
___Difficulty urinating
___Urgency
___Hesitancy
___Dribbling
___Loss of bladder control
___Burning on urination
___Blood in urine
___Loss of force of stream
___Loss of urine when coughing, sneezing, or laughing
___Urinating frequently at night
___Hernias
___Kidney disease
___Passing a stone

Endocrine

___Diabetes
___Bleeding problems
___Gout
___Abnormal thirst
___Thyroid disease
___Recent weight loss
___Recent weight gain

For Women Only

___Irregular periods
___Very Painful Periods
___Bleeding between periods
___Premenstrual bloating
___Premenstrual irritability
___Bleeding after intercourse
___Breast lumps
___Nipple discharge
___Trying to get pregnant
___Hot flashes
___Passed through menopause
___Bleeding after menopause
___Frequent bladder infection
___You could be pregnant

1. Date of last period
____
2. Birth control method
____

For Men Only

___Hard to start/stop urine stream
___Burning discharge from penis
___Swelling/lump in testicle
___Difficulty with erection
___Difficulty with ejaculation
___Prostrate trouble
___Birth control method

Habits

Do you currently smoke or chew tobacco? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No

How many packs per day? ____________________________ How many years?_________________________________

Do you drink alcohol, beer, or wine? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No

How many drinks? _______daily _______weekly ________monthly

Do you currently drink any caffeinated beverages such as coffee, tea or pop? ☐ Yes ☐ No

How many drinks? _______daily _______weekly ________monthly

Social History

Occupation (or prior occupation): ____

-currently working/retired/unemployed/leave of absence/disabled (circle one)

Date last worked: ___________________ Employer: ____

Years of education or highest degree: ____

Marital status: single/partner/married/divorced/widowed(circle one)

Spouse/partner's name: _______________________________ Number of children: ____ Ages of children _____________

Who lives at home with you? ____

Leisure activities, group involvement, religion, volunteer, work: ____

____

____

Medical History

Current health issues: ____

____

Have you ever been tested for hepatitis A, B or C? ☐ Yes ☐ No Which hepatitis virus? ___ ☐ Positive ☐ Negative

Have you been vaccinated for hepatitis A or B? ☐ Yes ☐ No If yes, date vaccine series completed _____________

Last Tuberculosis (TB) Screening? _________________ Result of TB screening: ☐ Positive ☐ Negative

Have you had a sexually transmitted disease? ☐ Yes ☐ No Diagnosis: ______________________________________

Do you have HIV disease / AIDS? ☐ Yes ☐ No

Tetanus booster in the last 10 years? ☐ Yes ☐ No ☐ Unsure

Past Surgical History

Have you ever been hospitalized? ☐Yes ☐ No

If yes, for what? ____

____

Please list all surgeries you have had and the date of surgery:

1.____

2.____

3.____

4.____

5.____

6.____

Family History

Has any member of your family (including yourself, parents, siblings or children) had any of the following illnesses?

Illness	**Which family member?**
Alcoholism	
Diabetes	
Heart disease	
Heart attack	
Stroke	
Cancer	
Tuberculosis	
Ulcers	
Arthritis	
Obesity	
Suicide	
Glaucoma	
Thyroid trouble	
Asthma/allergies	

Other illness not listed above: ____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient Signature ____ Date __________________________