Epstein Neurosurgery Center, LLC
Epstein Neurosurgery Foundation, Inc. 501(c)(3)
Clara Raquel Epstein, MD, FICS
Neurosurgeon/CEO
www.epsteincenter.com
www.epsteinfoundation.org

Administrative Office:
6940 N. 63rd Street
Longmont, CO 80503-8852
Phone: 303.800.9129
Fax: 720.638.0497

PATIENT NAME _____ **DATE OF BIRTH** ___/_____/_____

Present Complaint:

_____

_____

Duration of complaints/problems: _____

PAST MEDICAL HISTORY: ☐ **NEGATIVE/UNREMARKABLE** or check box(es) that applies to you.

Medical

- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Disorder
- ☐ BPH
- ☐ Cancer- Breast
- ☐ Cancer – Lung
- ☐ Cancer- Renal
- ☐ Cancer- Colon
- ☐ Cancer- Prostate
- ☐ Cataracts
- ☐ COPD
- ☐ Depression
- ☐ Diabetes- Type 1
- ☐ Diabetes- Type 2
- ☐ Fibromyalgia
- ☐ GERD/Reflux
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis type: _____
- ☐ HIV
- ☐ High cholesterol/lipids
- ☐ Hypertension/High BP
- ☐ Irritable Bowel
- ☐ Heart Attack
- ☐ Nasal Allergies
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Thyroid Disease: low
- ☐ Vision loss

Neurologic

- ☐ Aneurysm
- ☐ CVA/Stroke
- ☐ Brain Tumor
- ☐ Hydrocephalus
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Peripheral
- ☐ Neuropathy
- ☐ Pituitary tumor
- ☐ Seizure Disorder
- ☐ Spinal Cord Injury
- ☐ TIA
- ☐ Traumatic Brain Injury /Concussion
- ☐ Trigeminal Neuralgia

Pertinent to Surgery

- ☐ Anticoagulation Therapy
- ☐ Bleeding Disorder
- ☐ Chronic Pain
- ☐ Clotting Disorder
- ☐ DVT
- ☐ Hemophilia
- ☐ Narcotic use >3 months
- ☐ Problems w/ Anesthesia
- ☐ Pulmonary Embolism
- ☐ Other: _____

Please list any other diagnosis not on this list:

_____

PAST SURGICAL HISTORY & HOSPITALIZATIONS: ☐ **NONE**

DATE OF SURGERY OR HOSPITALIZATION	PROCEDURE/REASON FOR HOSPITALIZATION	NAME OF SURGEON & FACILITY

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PATIENT NAME _____ **DATE OF BIRTH** ___/_____/_____

ALLERGIES: ☐**NO KNOWN DRUG ALLERGIES** or list medication, food and environmental allergies

Allergic to:	*Reaction:*

CURRENT MEDICATIONS: ☐ **NONE**

Medication name & dose ie Atenolol 50mg	**How often** *ie. one tab daily, one tab twice daily, two tabs at bedtime*

If you require more room, please list your medications, doses & frequency on a separate sheet of paper and attach.

FAMILY HISTORY: ☐**UNKOWN/ADOPTED** ☐**NO FAMILY HISTORY OF CHRONIC DISEASE**

or check the diagnosis that applies to your immediate family members (mom, dad, brother, sisters) AND list relationship **MTR** = Mother **FTR**=Father **BTR**= Brother **STR**=Sister

☐ FH Alcoholism	☐ FH Breast Cancer	☐ FH Hypertension/High BP	☐ FH Ovarian Cancer
☐ FH Anemia	☐ FH Cervical Cancer	☐ FH High Cholesterol	☐ FH Psychiatric Care
☐ FH Angina	☐ FH Colon Cancer	☐ FH Kidney Disease	☐ FH Respiratory disease
☐ FH Arthritis	☐ FH Depression	☐ FH Liver Disease	☐ FH Seizures
☐ FH Asthma	☐ FH Diabetes	☐ FH Lung Cancer	☐ FH Severe allergies
☐ FH Birth Defects	☐ FH Growth OR Development Problems	☐ FH Melanoma/Skin Cancer	☐ FH Stroke
☐ FH Blood Clots	☐ FH Headaches	☐ FH Osteoporosis	☐ FH Thyroid Disease
☐ FH Bowel Disease	☐ FH Heart Disease	☐ FH Other Cancer	☐ FH Uterine Cancer

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SOCIAL HISTORY/ADDITIONAL INFORMATION:

Tobacco Use:	☐Current every day smoker ☐Current some day smoker ☐Former Smoker **Tobacco Type (Cigarettes/Cigars/Chew)** _____ **Duration** _____**packs/year** ☐Never Smoker ☐**Passive Smoke Exposure**
Alcohol Use:	☐No ☐Yes Type: _____ How many drinks per day _____
Recreational Drug Use:	☐No ☐Yes Type: _____ How often _____
Seat Belt Use:	☐All the Time ☐Sometimes ☐Never
Smoke Detectors in Place of Residence:	☐Yes ☐No
Are you licensed to carry a firearm:	☐Yes ☐No If so, is it secured in your home? ☐Yes ☐No
Employment Status:	☐Employed ☐Unemployed ☐Retired ☐Disabled ☐Self-employed What is/was your occupation: _____
Education:	What is the highest grade or level of school you have completed or the highest degree you received?_____
Marital Status:	☐Married ☐Partner ☐Single ☐Divorced ☐Widowed

☐Right-hand dominant ☐Left-hand dominant ☐Ambidextrous	Height _____ Weight: _____ lbs.

This information is true and complete to the best of my knowledge.

_____ _____

Signature **Date**

_____

Patient Name (Printed)