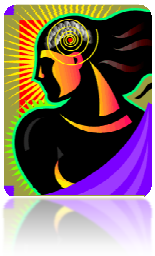

Epstein Neurosurgery Center, LLC
Epstein Neurosurgery Foundation, Inc. 501(c)(3)
Clara Raquel Epstein, MD, FICS
Neurosurgeon/CEO
www.epsteincenter.com
www.epsteinfoundation.org

Administrative Office:
1245 Pearl Street, Suite#210
Boulder, CO 80302
Phone: 303.800.9129
Fax: 720.638.0497

Patient Name: _____ DOB: _____/_____/_____ mm/dd/yy

Present Complaint _____

_____

Duration of complaints/problems: _____

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

Medical	**Medical**	**Neurologic**	**Pertinent to surgery**
Anemia	GERD/Reflux	Aneurysm	Anticoagulation Therapy
Anxiety	Glaucoma	CVA/Stroke	Bleeding Disorder
Asthma	Gout	Brain Tumor	Chronic Pain
Atrial Fibrillation	Heart Disease	Hydrocephalus	Clotting Disorder
Autoimmune Disorder	Hepatitis type:_____	Migraines	DVT
BPH	HIV	Multiple Sclerosis	Hemophilia
Cancer- Breast	High cholesterol/lipids	Parkinsons Disease	Narcotic use > 6 months
Cancer – Lung	Hypertension/High BP	Peripheral Neuropathy	Problems w/ Anesthesia
Cancer- Renal	Irritable Bowel Syndrome	Pituitary tumor	Pulmonary Embolism
Cancer- Colon	Heart Attack	Seizure Disorder	Other:
Cancer- Prostate	Nasal Allergies	Spinal Cord Injury	
Cataracts	Osteoarthritis	TIA	
COPD	Osteoporosis	Traumatic Brain Injury	**Please list any other diagnosis not on this list:**
	Renal Disease		
Depression	Rheumatoid Arthritis	Trigeminal Neuralgia	
Diabetes- Type 1	Sleep Apnea	Other:	
Diabetes- Type 2	Thyroid Disease: high low		
Fibromyalgia	Vision loss		

PAST SURGICAL HISTORY:NO PREVIOUS SURGERIES

Year of surgery:	*Type of surgery and surgeon.*

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:
1245 Pearl Street, Suite#210
Boulder, CO 80302
Phone: 303.800.9129
Fax: 720.638.0497

Patient Name: _____

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)

FH Alcoholism	FH Breast Cancer	FH Hypertension/High BP	FH Ovarian Cancer
FH Anemia	FH Cervical Cancer	FH High Cholesterol	FH PsychiatricCare
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/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

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:
1245 Pearl Street, Suite#210
Boulder, CO 80302
Phone: 303.800.9129
Fax: 720.638.0497

Patient Name: _____

SOCIAL HISTORY/ADDITIONAL INFORMATION:

Tobacco use:	Current every day smoker Current some day smokerFormer Smoker Never Smoker **Passive Smoke Exposure**Yes No
Alcohol Use	No Yes, Type:_____ How many drinks per day _____
Recreational Drug Use:	No Yes, Type: _____ How often _____
Employment Status:	Employed Unemployed Retired Disabled Self-employed What is or was your occupation: _____
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**