

COLUMBIA NEUROSURGERY & SPINE, PLLC  
 Matthew Fewel, MD \_ Tom Nagle, PA-C  
 833 SWIFT BLVD.  
 RICHLAND, WA 99352  
 (509) 942-3080 · FAX (509) 942-3085

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First M.I.  
 Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B/P \_\_\_\_\_ Pulse \_\_\_\_\_ Temp \_\_\_\_\_

**REASON FOR VISIT** \_\_\_\_\_

**REFERRING PHYSICIAN** \_\_\_\_\_

**FAMILY HISTORY**

List any blood relative that has had or died from any of the following (include age)  check ALL that apply:

- Cancer \_\_\_\_\_  Diabetes \_\_\_\_\_  Epilepsy \_\_\_\_\_
- Heart disease \_\_\_\_\_  High blood pressure \_\_\_\_\_  Blood diseases \_\_\_\_\_
- Congenital problems \_\_\_\_\_  Aneurysms \_\_\_\_\_  Brain tumors \_\_\_\_\_
- Stroke \_\_\_\_\_  Problems with anesthesia \_\_\_\_\_  Other \_\_\_\_\_

**PAST MEDICAL HISTORY** Do you now or have you ever had? (Check  if “yes”)

<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> GERD	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Kidney failure
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Parkinson’s Disease
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Pulmonary embolus	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Tumor (benign)	<input type="checkbox"/> Tumor (malignant)	<input type="checkbox"/> Other

**SOCIAL HISTORY**

Occupation: \_\_\_\_\_ Present employer: \_\_\_\_\_  
 Married  Single  Retired  Living Independently      Number of children: \_\_\_\_\_  
 Do you drink alcohol?  No  Yes, type and number of drinks/week \_\_\_\_\_  
 Do you smoke?  No  Yes, packs per day \_\_\_\_\_ years smoked \_\_\_\_\_  Past, quit when? \_\_\_\_\_  
 Do you use drugs for reasons that are not medical?  No  Yes, please list: \_\_\_\_\_  
 Hobbies/Avocation: \_\_\_\_\_

**PAST SURGICAL HISTORY**

Type of Surgery	Year	Reason for Surgery
1.		
2.		
3.		
4.		
5.		

COLUMBIA NEUROSURGERY & SPINE, PLLC  
 Matthew Fewel, MD \_ Tom Nagle, PA-C  
 833 SWIFT BLVD.  
 RICHLAND, WA 99352  
 (509) 942-3080 · FAX (509) 942-3085

Have you ever had a blood transfusion?  Yes, what year? \_\_\_\_\_  No  
 Are you pregnant?  Yes  No

**PRESENT MEDICATIONS**  Yes  No (list including aspirin, laxatives, vitamins, herbs, and other supplements :)

Drug Name	Dose(mg)	Frequency(times per day)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

**DRUG ALLERGIES**  Yes, please list  No:

Drug Name	Reaction (rash, difficulty breathing, anaphylaxis, etc.)
1.	
2.	
3.	
4.	

**SYSTEMS REVIEW** Please  check ALL which have significantly affected you and explain:

<input type="checkbox"/> Weight loss	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Seizures
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Memory loss
<input type="checkbox"/> Fevers	<input type="checkbox"/> Constipation	<input type="checkbox"/> Headaches
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Weakness
<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Numbness
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Kidney infections	<input type="checkbox"/> Vision loss
<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Bladder infections	<input type="checkbox"/> Double vision
<input type="checkbox"/> Swelling of feet/ankles	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Hearing loss
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Sexual dysfunction	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Impotence	<input type="checkbox"/> Depression
<input type="checkbox"/> Rashes, sores	<input type="checkbox"/> Balance difficulty	<input type="checkbox"/> Anxiety

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_