

**ST.LUKE'S ROOSEVELT HOSPITAL CENTER
DEPARTMENT OF NEUROSURGERY
DR. CHANDRANATH SEN
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NEW YORK, NY 10019
TEL: 212-523-6720
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MEDICAL HISTORY FORM

Date: _____

Name: _____ Sex ()M () F Age: _____

Have you had a major problem with any of the following, if so, please circle and detail:

Circle:

Yes/No Weight Loss, Fever _____

Yes/No Heart or Cardiovascular System _____

Yes/No Respiratory _____

Yes/No Kidneys or Genitourinary System _____

Yes/No Skin _____

Yes/No Cancer _____

Yes/No Neurologic System (including Spine) _____

Yes/No Lungs _____

Yes/No Gastrointestinal System _____

Yes/No Endocrine System (including Diabetes) _____

Yes/No Eyes or Ears _____

Yes/No Psychological/Psychiatric (including Depression) _____

Previous Hospitalization (including Surgery):

Name of Hospital	Date(s)	Reason
_____	_____	_____
_____	_____	_____

Allergies:

Drug Name

Dose

Family History: (List any pertinent family history related to your current problem or family disease inherited through blood relatives)

Social History:

Marital Status: () Single () Married () Divorced () Widowed

Are you employed? () Yes () No In what capacity? _____

Do you smoke? () Yes () No How often? _____ How long? _____

Do you drink? () Yes () No How often? _____ How long? _____

If female and of childbearing age, are you pregnant? () Yes () No

If female and of childbearing age, are you on birth control pills? () Yes () No

If appropriate, add further medical history, or continue medication list below:

Patient Signature

Date