neurotexas®
Brain and Spinal Surgery

Name: _____

DOB: _____

Date: _____ Weight: _____

Height: _____

1. Has any of your contact information or insurance changed? Yes / No ☐ ☐
   (If yes, please provide new info to receptionist)

Send Visit Note to Provider?

2. Referring Physician: _____ ☐
3. Primary Care Physician: _____ ☐
4. Pain Management Physician: _____ ☐
5. Cardiologist: _____ ☐
6. Is this a post-operative visit (within 90 days of surgery)? Yes / No
7. If yes, date of surgery: _____
8. Purpose of today's visit/chief complaint?

_____

9. Any changes since your last visit?

_____

10. On a scale of 1-10, how bad is your pain today? _____
11. Have you had any tests or imaging since your last visit? (Circle all that apply)

    X-Ray MRI CT Scan Myelogram EMG Discogram (Other)

12. Where was this done? _____
13. Tobacco Use: Yes / No Frequency: _____
14. Alcohol Use: Yes / No Frequency:_____
15. Allergies: Yes / No _____

List ALL medications you are currently taking.

MEDICATION	DOSAGE	FREQUENCY	DURATION