



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

**Clinical Office (By Appointment Only):**  
 109 N. 2nd St., Suite #102  
 Westcliffe, CO 81252  
 Phone: 303.800.9129 Fax:  
 720.638.0497

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_

**Present Complaint:**

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**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:

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

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



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

Allergic to:	Reaction:

**CURRENT MEDICATIONS:**  **NONE**

Medication name & dose	How often
ie Atenolol 50mg	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

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



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**SOCIAL HISTORY/ADDITIONAL INFORMATION:**

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

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

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Name (Printed)**