PRE-SURGERY EVALUATION INTAKE
PATIENT NAME

PATIENT DATE OF BIRTH

PATIENT ADDRESS

PATIENT TELEPHONE

PATIENT EMAIL

EMERGENCY CONTACT

SURGEON'S NAME, ADDRESS, AND PHONE NUMBER

PATIENT INSURANCE		
☐ Medicare	☐ Medicaid	☐ BCBS of AZ
☐ Self-Pay		

CURRENT LIVING SITUATION - TYPE		
☐ Personal Home	☐ Assisted Living Facility	☐ Skilled Nursing Facility
☐ Rehab Facility	☐ Group Home	☐ Shelter
☐		

CURRENT LIVING SITUATION – WITH WHOM?		
☐ Spouse/Partner	☐ Sibling	☐ Adult Child
☐ Other Family	☐ Friend	☐ Alone

MARITAL STATUS		
☐ Married	☐ Divorced	☐ Separated
☐ Widowed	☐ Single	☐

REFERRAL SOURCE		
☐ Primary Care Physician	☐ Neurologist	☐ SNF/ALF
☐ Self	☐	☐

LANGUAGE(S)	
☐ English Only	
☐ Bilingual (2 languages equally well)	Other Language:
☐ 2 Languages, English Primary	Other Language:
☐ 2 Languages, English NOT Primary	Other Language:
Language spoken in home by parents (when you were growing up):	

EDUCATION			
☐ High School Graduate	Date:	☐ 2 Year College Degree	Date:
☐ 4 Year College Degree	Date:	☐ Master's Degree:	Date:
☐ Doctorate	Date:	☐	
☐ Less than HS Grad		Highest Grade Completed:	
☐ History of Special Education			

MEDICAL CONDITIONS		
☐ Diabetes	☐ HIV	☐ Stroke/CVA
☐ Congestive Heart Failure	☐ Parkinson's Disease	☐
☐ Hypertension	☐ Huntington's Disease	☐
☐ Prion Disease	☐ TBI	☐

MEDICATIONS		
Name	**Dose**	**Purpose**

MENTAL HEALTH CONDITIONS		
☐ Depression	☐ Bipolar	☐ Anxiety
☐ Auditory Hallucinations	☐ Visual Hallucinations	☐ Delusions
☐ PTSD	☐ ADHD	☐ Learning Disorder
☐	☐	☐

MENTAL HEALTH TREATMENT			
Date	**Provider**	**Reason**	**Helpful?**

EMPLOYMENT			
Date	**Company**	**Position**	**Why Left?**

LEGAL HISTORY			
Arrests/Reason	**Convicted?**	**Incarcerated?**	**Date**

SUBSTANCE USE		
Substance	**Last Use**	**Frequency of Use**
☐ Heroin		
☐ Cocaine		
☐ Methamphetamines		
☐ Amphetamines		
☐ Barbiturates		
☐ Ecstasy		
☐ LSD		
☐ Marijuana		
☐ PCP		
☐ Spice		
☐ Bath Salts		
☐ Inhalants (huffing)		
☐ Rx Narcotics		
☐ Rx Sedatives		
☐ Alcohol		
☐ Tobacco		
☐ Caffeine		
☐		
☐		

FAMILY				
Significant Family Members	**Age**	**Name (optional)**	**Deceased?**	**Living with You?**
Mother				
Father				
Sibling				
Sibling				

Sibling
Sibling
Sibling
Spouse
Partner
Child
Child

Please indicate the type of surgery you will be receiving and the reasons for the surgery: