DR JOHN W FULLER
NEUROSURGEON

Clinical Information Form (confidential)

Patient Name: _____

Reason for Referral: _____

Occupation: _____

Are you right or left handed? Right [ ] Left [ ]

Do you have any of the following? (please tick) Heart Problems [ ] Epilipsy / Seizures [ ]

High Blood Pressure [ ] Dizzy Spells [ ] Kidney Problems [ ] Fainting [ ]

Do you smoke? Yes [ ] No [ ] How much? _____

Are you an ex-smoker? Yes [ ] No [ ]

Do you drink alcohol? Yes [ ] No [ ] How much? _____

Are you taking Asprin? Yes [ ] No [ ] Are you taking Warfarin? Yes [ ] No [ ]

Are you taking Clopidogrel / Plavix / Iscover / Zarelto? Yes [ ] No [ ]

Family member history of similar illness? Yes [ ] No [ ]

Previous Illnesses:	Year:	Previous Operations:	Year:

Medications: _____ Dose: _____ Times per day: _____

_____ _____ _____

_____ _____ _____

Allergies? Yes [ ] No [ ]

Drug: _____ Reaction: _____