



Jeffrey D. Gross M.D.
NEUROLOGICAL SURGERY

27882 Forbes Road
Laguna Niguel, CA 92677

Request for Consultation:

If you would like to schedule an appointment with Dr. Gross, please complete the following form and fax to (949) 364-6333, or mail the form to the address above. If your problem constitutes an emergency, this method of communication would not be necessarily timely enough, and you should contact your primary physician, or if a real medical emergency exists, call 911.

PERSONAL INFORMATION

NAME: First MI Last

HOME ADDRESS:

HOME PHONE: Check if preferred contact number:

CELL PHONE: Check if preferred contact number:

PLACE OF EMPLOYMENT:

WORK ADDRESS:

WORK PHONE: Check if preferred contact number:

CHECK ONE:

INDICATE RELATIONSHIP OF SECONDARY CONTACT:

SPOUSE GUARDIAN NEAREST RELATIVE

SPOUSE, GUARDIAN, OR NEAREST RELATIVE:

Name

Address

Phone

Check if contact information is the same as above.

AGE: Age D.O.B.



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PATIENT QUESTIONNAIRE

MY CHIEF PROBLEM IS:

THIS HAS BEEN GOING ON FOR: _____

EVER SINCE MY _____

DESCRIBE LOCATION OF PAIN:

DESCRIBE NATURE OF PAIN:

LOCATION AND DESCRIPTION OF NUMBNESS OR TINGLING:

LOCATION AND DESCRIPTION OF WEAKNESS:

HOW HAVE THESE SYMPTOMS CHANGED YOUR LIFE, OR YOUR ABILITY TO PERFORM YOUR USUAL FUNCTIONS?:



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PATIENT QUESTIONNAIRE 2

WHAT MAKES THESE SYMPTOMS BETTER?

WHAT MAKES THESE SYMPTOMS WORSE?

WHAT HAVE YOU TRIED FOR THESE SYMPTOMS?

DO YOU HAVE PROBLEMS CONTROLLING YOUR BOWEL OR BLADDER?

DO YOU HAVE TROUBLE WALKING?

DO YOU HAVE OTHER MEDICAL PROBLEMS?

PLEASE LIST ANY AND ALL SURGERIES THAT YOU HAVE HAD:



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PATIENT QUESTIONNAIRE 3

WHAT MEDICINES, VITAMINS, HERBS, OR SUPPLEMENTS DO YOU TAKE?

DO YOU HAVE ALLERGIES TO MEDICATIONS?

PLEASE LIST ANY MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY:

DO YOU SMOKE? _____ IF SO, HOW MUCH & HOW LONG? _____

DO YOU DRINK ALCOHOL? _____ IF SO, HOW MUCH & HOW LONG? _____

WHAT IS YOUR WEEKLY ACTIVITY LIKE? (i.e., list exercises, physical activity, etc.)

ARE YOUR SYMPTOMS RELATED TO A WORK-RELATED INJURY?



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Aside from the problem for which you are seeking help from me, do you have any of the following (Please circle the item(s) and explain below):

PATIENT QUESTIONNAIRE 4

GENERAL/CONSTITUTIONAL

Fevers, Chills, Nausea, Vomiting, Lethargy, Fast or slow heart beat, lapses of consciousness or memory

SKIN/BREASTS

Rashes, lumps under the skin, easy bruising, easy bleeding

EYES/EARS/NOSE/MOUTH/THROAT

Sore throat, difficulty swallowing or getting food down, stuffed nose or sinuses, hoarseness

CARDIOVASCULAR

Chest pain, skipped or irregular heart beats

RESPIRATORY

Trouble breathing, frequent coughing, production of sputum, blood in sputum

GASTROINTESTINAL

Bloating, abdominal pain, pain after eating, trouble with bowel movements

GENITOURINARY

Trouble starting or stopping urine flow, leakage of urine, impotence, incontinence, blood in the urine or burning on urination

MUSCULOSKELETAL

Pain in the joints, limitation of range of motion, cramping in the muscles

NEUROLOGIC/PSYCHIATRIC

Problems controlling mood, loss of appetite or sleepiness, sleeping too much, trouble with balance or walking, problems with vision, hearing, taste, and/or smell

continued



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Aside from the problem for which you are seeking help from me, do you have any of the following (Please circle the item(s) and explain below):

PATIENT QUESTIONNAIRE 4 continued

ALLERGIC/IMMUNOLOGIC/LYMPHATIC/ENDOCRINE

Swollen lymph glands, frequent infections or illness, milk from the breasts

Please explain



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PATIENT QUESTIONNAIRE 5

WHAT TESTS, XRAYS, MRI'S HAVE YOU HAD?

YOUR PRIMARY PHYSICIAN IS:

Name
Address
Phone

YOUR REFERRING PHYSICIAN IS:

Name
Address
Phone