

Riverside Hampton Roads Neurology

Date _____

Doctor _____

Grp Mgmt # _____

PATIENT INFORMATION UPDATE (2010)

PATIENT:

First Name: _____ MI: _____ Last Name: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Marital Status: _____

Soc. Sec. No. _____ Email Address: _____

Employer: _____ Work Phone: _____

Pharmacy: _____ Pharmacy Phone/Location: _____

INSURANCE:

Primary: _____ Secondary: _____

Group Number: _____ Group Number: _____

Policy Number: _____ Policy Number: _____

Relationship of Patient: _____ Relationship of Patient: _____

Subscriber's Name: _____ Subscriber's Name: _____

Date of Birth: _____ Date of Birth: _____

Soc. Sec. No: _____ Soc. Sec. No: _____

NEXT OF KIN: (Spouse, Parent or Emergency Contact)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Whom may we thank for referring you to us?: _____

****PLEASE COMPLETE NEXT PAGE****

PLEASE READ CAREFULLY!

The physicians and staff of Riverside Hampton Roads Neurology want to welcome you to our practice. We continue to strive to provide you with the best medical care possible. Here at Riverside Hampton Roads Neurology we take your confidentiality seriously. By signing below you acknowledge that we have given you a copy of the HIPPA Privacy Act.

Signature: _____ Date: _____

Without your permission, we will **NOT** release any of your medical information pertaining to lab results, diagnosis, even appointments. If you want to allow anyone to have access to **all** of your care, please list them below:

Name: _____ Relationship to you: _____ Initials: _____

Name: _____ Relationship to you: _____ Initials: _____

Name: _____ Relationship to you: _____ Initials: _____

In order to assist you with your insurance needs, we will gladly file the necessary forms to expedite insurance payments from your primary insurance company, as well as any secondary insurance you may have. Your assistance and understanding of your specific insurance policy, as well as our payment policy, will be of great benefit to our relationship. We will make every effort to answer any question you may have whenever possible. Please be aware of the following, which are some areas that are frequently misunderstood.

1. Not all services are a covered benefit under all policies. Some insurance companies arbitrarily select certain services that they will not cover. It is up to you, the patient, to know what these services are. _____ Initial
2. Some insurance policies have higher co-payments for a specialist physician than that of your Primary Care Physician. Please refer to your card or contract for the amount. _____ Initial
3. All co-payments, and deductibles that have not been met and charges for services that are not covered by your contract, are **due at the time of your visit upon checkout.** _____ Initial

Your signature below, which is required on an annual basis, is your acknowledgement that the information on the front of this sheet is true and correct. It also serves as your authorization to release any necessary medical information to your insurance carrier and to process claims for services rendered.

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

MEDICAL HISTORY

DATE: _____

PHYSICIAN: _____

NAME _____ AGE _____ DATE OF BIRTH _____

REASON FOR SEEING NEUROLOGIST TODAY? _____

OCCUPATION _____ EDUCATION _____ HEIGHT _____ WEIGHT _____

DO YOU LIVE: ALONE SPOUSE PARENTS CHILDREN RELATIVES ROOMATE**ALLERGIES** MEDICATION ALLERGIES _____ FOOD _____ OTHER _____**HEALTH PROBLEMS (CHECK THE BOXES THAT APPLY)**

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> CATARACTS | <input type="checkbox"/> HIV POSITIVE | <input type="checkbox"/> SPINAL CORD INJURY |
| <input type="checkbox"/> ALZHEIMER DISEASE | <input type="checkbox"/> DIABETES | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> STROKE OR TIA |
| <input type="checkbox"/> APPENDICITIS | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> LIVER PROBLEMS | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> OTHER (EXPLAIN) |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> MENINGITIS | _____ |
| <input type="checkbox"/> BLEEDING PROBLEMS | <input type="checkbox"/> GOUT | <input type="checkbox"/> MENTAL ILLNESS | _____ |
| <input type="checkbox"/> BRAIN INJURY | <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> MIGRAINE HEADACHES | _____ |
| <input type="checkbox"/> BROKEN BONES | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> MULTIPLE SCLEROSIS | _____ |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HERPES | <input type="checkbox"/> PACEMAKER | _____ |
| <input type="checkbox"/> ↑ CHOLESTEROL | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> PNEUMONIA | _____ |

HOSPITALIZATIONS: HOSPITAL: _____ DATE: _____
REASON: _____ PHYSICIAN: _____**SURGERIES:** _____
_____**CHECK (X) IF FAMILY MEMBER HAD ANY OF THE FOLLOWING:**

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> ALZHEIMER DISEASE | <input type="checkbox"/> CANCER | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> PARKINSON DISEASE |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DIABETES | <input type="checkbox"/> MIGRAINES | <input type="checkbox"/> PSYCHOLOGICAL PROBLEM |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EPILEPSY OR SEIZURES | <input type="checkbox"/> MULTIPLE SCLEROSIS | <input type="checkbox"/> STROKE OR TIA |
| <input type="checkbox"/> BRAIN INJURY | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> MUSCLE PROBLEMS | <input type="checkbox"/> TREMORS OR SHAKING |
| <input type="checkbox"/> BREATHING PROBLEM | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> NERVE PROBLEMS | <input type="checkbox"/> OTHER |

HEALTH AND SOCIAL HABITS

CIGARETTES NEVER QUIT _____ (WHEN) CURRENT SMOKER _____ PACKS PER DAY FOR _____ YEARS

OTHER TOBACCO PIPE CIGAR SNUFF CHEW

ALCOHOL DO YOU DRINK ALCOHOL? YES NO # DRINKS PER WEEK _____

DRUG USE DO YOU USE RECREATIONAL DRUGS? YES NO WHICH ONES _____

HAVE YOU EVERY USED NEEDLES TO INJECT DRUGS YES NO

CAFFEINE COFFEE INTAKE YES NO # _____ CUPS PER DAY COFFEE / TEA / SODA

HISTORY OF: PHYSICAL ABUSE YES NO SEXUAL ABUSE YES NO SUBSTANCE ABUSE YES NO

FAMILY HISTORY (FILL IN HEALTH HISTORY ABOUT YOUR FAMILY)

RELATION IF LIVING	STATE OF HEALTH	MEDICAL PROBLEMS	AGE & CAUSE OF DEATH
FATHER			
MOTHER			
SIBLINGS			
CHILDREN			

SYMPTOMS

✓ CHECK ALL THAT APPLY

UNCHECKED BOX = REVIEWED & NEGATIVE

NAME: _____

DATE: _____

GENERAL

- ANOREXIA
- BLOOD TRANSFUSION
- CHILLS
- DIZZINESS
- FAINTING
- FATIGUE
- FEVER
- HEADACHE MALAISE
- NERVOUSNESS SWEATS
- UNUSUAL WEAKNESS
- WEIGHT LOSS/GAIN

ALLERGIC/IMMUNE

- DUST ALLERGY
- HAY FEVER/POLLEN
- HIVES
- HIV HIV EXPOSURE
- IMMUNE DISORDER

CARDIOVASCULAR

- ANKLE SWELLING
- CHEST PAIN
- CONGESTIVE HEART FAILURE
- COUGHING BLOOD
- FAINTING (SYNCOPE)
- HEART MURMUR
- HEART ATTACK
- HIGH BLOOD PRESSURE
- HIGH CHOLESTEROL
- IRREGULAR HEART BEAT
- CAN'T BREATHE LYING DOWN
- LEG PAIN WITH EXERCISE
- PALPITATIONS
- POOR CIRCULATION
- RAPID HEART BEAT
- SHORTNESS OF BREATH
- " " " ON EXERTION
- VARICOSE VEINS

EYE, EAR, NOSE

- BLEEDING GUMS
- BLURRED OR DOUBLE VISION
- CHRONIC SINUS PROBLEM
- CROSSED EYES
- DIFFICULTY SWALLOWING
- EARACHE
- EAR DISCHARGE
- HOARSENESS/ VOICE CHANGE
- LOSS OF HEARING
- NASAL CONGESTION
- NOSE BLEED
- RINGING IN EARS
- SORE THROAT

ENDOCRINE

- DIABETES
- EXCESSIVE SKIN DRYNESS
- EXCESSIVE THIRST
- EXCESSIVE URINATION
- HEAT OR COLD INTOLERANCE
- HORMONE PROBLEMS
- HOT FLASHES
- THYROID DISEASE

EYES

- BLURRED OR DOUBLE VISION
- CATARACTS
- DISCHARGE
- DROOPING EYELIDS
- EYE PAIN
- GLAUCOMA
- IRRITATION
- SENSITIVE TO LIGHT
- VISION CHANGE OR LOSS

GASTROINTESTINAL

- ABDOMINAL PAIN
- ABNORMAL LIVER TEST
- FREQUENT / LONG TERM ASPIRIN USE
- BLACK STOOLS
- BLOOD IN STOOLS
- BLOATING
- BOWEL CHANGES
- CONSTIPATION
- DIARRHEA
- GAS
- INDIGESTION OR HEARTBURN
- HEPATITIS
- NAUSEA OR VOMITING
- PEPTIC ULCERS
- RECTAL BLEEDING

GENITO-URINARY

- BLOOD IN URINE
- BURNING WITH URINATION
- ERECTILE DYSFUNCTION
- FLANK (SIDE) PAIN
- FREQUENT URINATION
- PAINFUL URINATION
- INABILITY TO CONTROL URINE
- KIDNEY DISEASE
- KIDNEY STONES
- SEXUALLY TRANSMITTED DISEASE
- LACK OF BLADDER CONTROL

SKIN

- CHANGE IN SKIN COLOR/MOLE
- RASH / ITCHING DRY SKIN
- SUSPICIOUS LESION

HEMATOLOGIC/LYMPH

- ANEMIA ABNORMAL BRUISING
- BLEEDING TENDENCY
- BRUISING TENDENCY
- PHLEBITIS
- LUMPS / SWOLLEN GLANDS

MUSCLE/JOINT/BONE

- FIBROMYALGIA STIFFNESS
- GOUT JOINT SWELLING
- ARTHRITIS
- PAIN OR WEAKNESS IN:**
- ARMS HIPS NECK
- BACK JOINTS
- BONES KNEES
- FEET LEGS
- HANDS MUSCLE

NEUROLOGICAL

- BALANCE
- CRAMPS OR PAIN
- CONVULSIONS OR SEIZURES
- DIFFICULTY WITH BALANCE
- DIZZINESS
- FAINTING
- HEADACHES
- HEAD INJURY
- LIGHTHEADEDNESS
- LOSS OF CONSCIOUSNESS
- MEMORY LOSS
- MUSCLE TWITCH
- NERVOUSNESS
- NUMBNESS OR TINGLING
- PARALYSIS
- SLURRED SPEECH
- STROKE / TIA
- TREMORS WEAKNESS

RESPIRATORY

- ASTHMA
- FREQUENT COUGH
- COUGHING UP BLOOD
- EMPHYSEMA EXCESS SPUTUM
- SHORTNESS OF BREATH
- WHEEZING

PSYCHIATRIC

- ALCOHOLISM
- ANXIETY CAN'T SIT STILL
- CRYING EPISODES DEPRESSION
- DRUG PROBLEM (NOW OR PAST)
- HALLUCINATIONS / DELUSIONS
- INSOMNIA IRRITABLE
- MEMORY LOSS

DATE:

PHYSICIAN:

UNCHECKED BOX = REVIEWED & NEGATIVE

