

# SYMPTOMS

NAME : \_\_\_\_\_

✓ CHECK ALL THAT APPLY

DATE : \_\_\_\_\_

## GENERAL

- Chills
  - Fatigue
  - Fever
  - Weight loss
- \_\_\_\_\_
- \_\_\_\_\_

## EYES

- Blurred or double vision
  - Discharge
  - Eye pain
  - Vision change or loss of vision
- \_\_\_\_\_
- \_\_\_\_\_

## NEUROLOGICAL

- Cramps or pain
  - Convulsions or seizures
  - Difficulty with balance
  - Dizziness
  - Headaches
  - Loss of consciousness
  - Memory loss
  - Muscle twitching
  - Numbness or tingling
  - Slurred speech
  - Tremors
  - Weakness
- \_\_\_\_\_

## ALLERGIC/IMMUNE

- Dust allergy
  - Hay fever/pollen
  - Hives
  - Immune disorder
- \_\_\_\_\_

## GASTROINTESTINAL

- Abdominal pain
  - Black stools/ bowel movements
  - Constipation
  - Diarrhea
- \_\_\_\_\_

## CARDIOVASCULAR

- Chest pain
  - Irregular heart beat
  - Palpitations
  - Shortness of breath on exertion
- \_\_\_\_\_
- \_\_\_\_\_

## GENITO-URINARY

- Blood in urine
  - Burning with urination
  - Inability to control urine
  - Painful urination
  - Sexual dysfunction
- \_\_\_\_\_

## RESPIRATORY

- Frequent cough
  - Excess sputum
  - Shortness of breath
  - Wheezing
- \_\_\_\_\_

## EYE, EAR, NOSE

- Loss of hearing
  - Nasal congestion
  - Ringing in ears
  - Vertigo
- \_\_\_\_\_

## HEMATOLOGIC/LYMPH

- Anemia
  - Bleeding tendency
  - Bruising Tendency
  - Lumps/Swollen glands
- \_\_\_\_\_

## PSYCHIATRIC

- Anxiety
  - Crying episodes
  - Depression
  - Hallucinations/delusions
  - Insomnia
  - Irritable
- \_\_\_\_\_

## ENDOCRINE

- Excessive thirst
  - Excessive urination
  - Heat or cold intolerance
  - Hot flashes
- \_\_\_\_\_

## MUSCLE/JOINT/BONE

- Muscle pain
  - Joint pain
  - Joint swelling
  - Stiffness
- \_\_\_\_\_

## SKIN

- Change in skin color/ mole
  - Dry skin
  - Rash/itching/dry skin
  - Suspicious lesion
- \_\_\_\_\_

Other Concerns:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician \_\_\_\_\_

\* UNCHECKED BOX = REVIEWED &amp; NEGATIVE

Date \_\_\_\_\_

# MEDICAL HISTORY

DATE: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

REASON FOR SEEING A NEUROLOGIST TODAY? \_\_\_\_\_

OCCUPATION \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

DO YOU LIVE ALONG     SPOUSE     PARENTS     CHILDREN     RELATIVES     ROOMMATE

ALLERGIES: \_\_\_\_\_

MEDICATION ALLERGIES \_\_\_\_\_

FOOD ALLERGIES \_\_\_\_\_ OTHER ALLERGIES \_\_\_\_\_

## PATIENT'S ' 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"/> ALZHEIMERS       | <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 PROBLEM | <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"/> ALZHEIMERS        | <input type="checkbox"/> CANCER               | <input type="checkbox"/> KIDNEY DISEASE     | <input type="checkbox"/> PARKINSON'S DISEASE    |
| <input type="checkbox"/> ARTHRITIS         | <input type="checkbox"/> DIABETES             | <input type="checkbox"/> MIGRAINES          | <input type="checkbox"/> PSYCHOLOGICAL PROBLEMS |
| <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/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 EVER USED NEEDLES TO INJECT DRUGS?     YES     NO

CAFFEINE     YES     NO    CUPS PER DAY \_\_\_\_\_

HISTORY PHYSICAL ABUSE     YES     NO    SEXUAL ABUSE     YES     NO    SUBSTANCE ABUSE     YES     NO

## FAMILY HISTORY (FILL IN HEALTH HISTORY ABOUT YOUR FAMILY)

	STATE OF HEALTH	MEDICAL PROBLEMS	AGE (CAUSE OF DEATH)
FATHER			
MOTHER			
SIBLINGS			
CHILDREN			



## **RIVERSIDE INPATIENT, ED, and AMBULATORY CONSENT & FINANCIAL RESPONSIBILITY**

This Consent applies to the Riverside facility above and all doctors and their groups on staff at Riverside (all will be referred to as "Riverside"). It also applies to the Patient and/or Responsible Person signing below.

I agree as follows:

1. **CONSENT TO TREATMENT:** I consent to treatment by Riverside and its medical staff. I understand that even the best medical treatment has the chance of an unexpected outcome.
2. **RIVERSIDE TEACHES:** Riverside helps teach new healthcare providers. I agree they may take part in my medical care.
3. **RELEASE OF PRESCRIPTION HISTORY:** I understand Riverside has the right to ask for any data regarding my medication history. Riverside also may get any data regarding my medication history. This includes data that may be held by the Virginia Prescription Monitoring Program and other sources.
4. **CONSENT TO AUDIOVISUAL RECORDING:** If I have an emergency, I agree my treatment may be videotaped for quality purposes. I agree these recordings may be reviewed by the Trauma Team. I understand the recordings will not be part of my medical record. I understand the recordings will be erased after review. I agree to videotaping:  
 Yes Or  No Initials \_\_\_\_\_
5. **HIV TESTING DISCLOSURE:** Under Virginia law, I may be tested for HIV, Hepatitis B or C viruses without my written or oral permission. I will be tested only if contact occurs during medical treatment. The results of these tests will be given, without my permission, to the person that came in contact with my body fluids.
6. **ASSIGNMENT OF BENEFITS:** I assign to Riverside any money which I may receive from any insurance, workers compensation or disability benefits related to my medical treatment. I authorize any attorney paying out such money to pay Riverside directly for what I owe on any Riverside bill.
7. **PAYMENTS DUE WHEN BILL RECEIVED:** I agree to pay my entire Riverside bill on time. Full payment is due when I receive my bill. If my bill is not paid on time, I agree to pay interest at the legal rate. I give permission to Riverside to apply any overpayment from another Riverside account to any other bill that I may owe.
8. **INSURANCE REFERRALS & PREAUTHORIZATIONS:** I understand that it is my responsibility to fully follow all my preauthorization steps. If I elect to be treated without a referral from an approved doctor, it is my sole responsibility to pay my bill. I understand that insurance may not pay anything if I am treated without a referral. I agree Riverside can send my bills to my insurance company.
9. **INDEPENDENT DOCTORS:** While at a Riverside facility, I may be given treatment from many different health care providers. Some of these providers are employees of Riverside. Other providers are not employees of Riverside. For example, I may receive treatment from a specialist or others on the medical staff who are not employees of Riverside. I may receive a separate bill from these doctors for which I need to pay. I will also need to pay a separate Riverside bill.
10. **PRIVATE ROOM REQUEST:** I  choose Or  do not choose a private room. If I choose a private room I will need to pay more each day. I agree to pay the additional rate at the current Riverside rate for private rooms.
11. **RIVERSIDE NOT RESPONSIBLE FOR LOSS OF PERSONAL ITEMS:** Riverside will not be held accountable for any loss, theft or damage to any of my belongings. Riverside only will be accountable for my belongings that they take into their care. I will receive an itemized receipt for those items taken into Riverside's care.



**RIVERSIDE INPATIENT, ED, and AMBULATORY  
 CONSENT & FINANCIAL RESPONSIBILITY**

- 12. **CORRECT DATA:** I agree all data given to Riverside for my application for Medicare, Medicaid or any other state funded medical assistance is correct. I also assign any benefits payable for doctor's services to the doctor or place providing care. I give permission to such doctor or place to submit a claim to Medicare for payment.
- 13. **ADVANCE DIRECTIVE** I have been asked if I have an Advance Directive, Medical Power of Attorney or Durable Do Not Resuscitate Order (DDNR). These documents tell doctors what care I want. They also tell doctors what care I do not want when I am unable to tell them. It is Riverside's policy to honor your Advance Directive, Medical Power of Attorney, and DDNR. However, life support will be given, if needed, during surgery and any outpatient/ ambulatory center treatment except to terminally ill patients who tell us they do not want life support. Riverside has told me in writing my rights under Virginia law on how to make decisions concerning my medical care.
- 14. **REPLY TO THIRD PERSON QUESTIONS REGARDING STATUS:** If someone asks about me, Riverside may give my name, location, and my general medical state. I have the right to ask that these facts not be given to a third person. My family and doctor also have the right to ask that these facts not be given to a third person.
- 15. **NOTICE OF PRIVACY PRACTICES:** I have been told of Riverside's Notice of Privacy Practices. I have been offered a copy of Riverside's Notice of Privacy Practices.
- 16. **PATIENT E-MAIL:** By providing my e-mail address to Riverside, I permit them to use my e-mail address to send me messages on health related issues. I also permit them to use my e-mail address to send me messages on health services. In addition, I give permission to Riverside to e-mail me regarding clinical studies that match my medical situation. I understand I can choose not to receive such messages from Riverside by contacting them.

I AGREE TO THE TERMS OF THIS AGREEMENT.

Print Patient's Name	Date & Time
Patient or Responsible Person Signature	Relationship to Patient
Witness	Date & Time

**FOR OFFICE USE ONLY:**

- Patient Unavailable for Signature; Patient cannot sign, Give Reason \_\_\_\_\_
- Patient does not want to get a copy of this document.     Patient requested and was given a copy of this document.
- No Responsible Person Available    Staff Member Initials: \_\_\_\_\_ Date: \_\_\_\_\_

