THE NEUROLOGIC GROUP OF BUCKS/MONTGOMERY COUNTY-Patient Information Sheet

Today's Date_____ Age_____ Date of Birth**:**_____Sex M F

Name:_____Soc Sec No._____

Address_____

_____

Phone (H)_____(W)_____(C)_____

Referring Doctor:_____ Primary Doctor_____

Emergency Contact Name:_____Phone:_____

Pharmacy Name and Address:_____

Height____ft____in_ **Weight**_____lbs;

Medication Allergies:_____**Latex Allergy: Y N**

RACE: ☐White ☐Black/African American ☐ American Indian/Alaskan Native
☐Asian ☐Native Hawaiian or Pacific Islander ☐Other

ETHNICITY: Spanish/Hispanic Origin ☐ Yes ☐No PRIMARY LANGUAGE: _____

INSURANCE INFORMATION (card will be copied here)

INSURANCE INFORMATION Motor Vehicle or Worker's Compensation Only (circle if applicable)

INSURANCE CO_____CLAIM # _____

Address_____Date of Injury_____

Phone no._____

EMPLOYER:_____Address_____

I authorize the release of any medical information to the above named insurance company/companies and physicians and authorize payment of medical benefits to the Neurologic Group, The Epilepsy Center, and/or The Headache and Pain Center of Bucks/Montgomery County. I assume responsibility for payment of services not reimbursed by insurance .

DATE_____PATIENT SIGNATURE_____

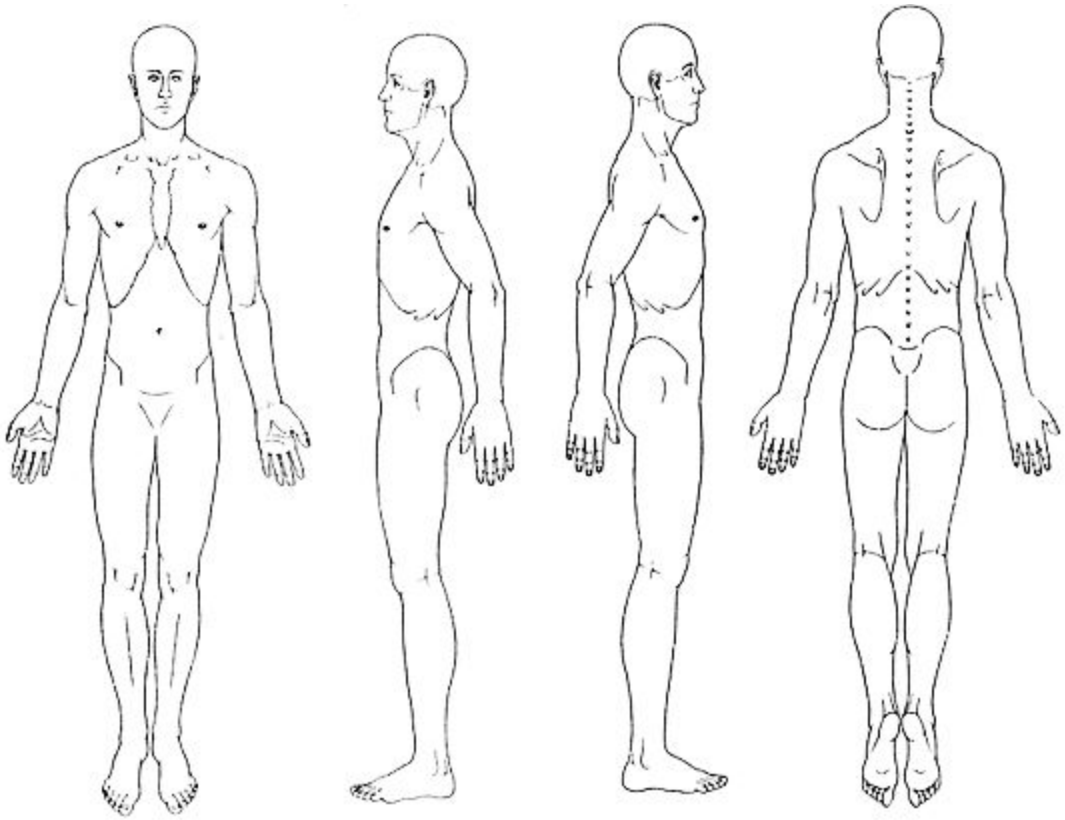
Rev. 11/25/15

THE NEUROLOGIC GROUP of BUCKS/MONTGOMERY COUNTY- PATIENT HEALTH HISTORY

Reason for Appointment:_____

How and when did this problem start?_____

Please mark carefully on the drawings the specific **location** of your pain , numbness or tingling if present. If your pain radiates to another area use an **Arrow** to show the pattern of radiation.



Circle the words that **BEST** describe your pain:

Dull
Aching
Deep
Cramping
Sharp
Burning
Numb /Tingling
Pins/Needles
Shooting
Heavy
Bony
Shock like
Sore
Tight/stiff
Spasms

If this is a **pain** related problem, please complete the remainder of this page, otherwise skip to next page.
Using the scale from 0-10, mark the number that **best** describes your **average** pain severity over the last week.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN EVER

Is your pain constant ? ☐Yes ☐No If not, how long does an episode last?_____
When during the day is your pain at its worst?_____? When is it best? _____
Does it wake you from sleep?_____

What brings on your pain or makes your pain worse? (circle all that apply)
Stress Work Sitting Standing Lying down Bending Climbing stairs Stretching Exercise Fatigue Driving Cold weather Movement Coughing Sneezing Lack of Sleep Other

What have you tried that makes your pain better? (circle all that apply)
Heat Ice Shower/bath Stretching Exercise Massage Physical therapy Chiropractic Acupuncture Tens-Unit Nerve block/epidural steroids Trigger point injections Medication Other

CURRENT MEDICATIONS- Please list medication and dosage

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.
MEDICAL CONDITIONS - Past or Current	**PAST SURGERIES** **Past orthopedic injuries/accidents/major traumas**

REVIEW of SYSTEMS - Have you had any of the following symptoms in the last 3 months? circle all that apply.

Constitutional: fever, chills, night sweats, fatigue , unexpected weight loss, unexpected weight gain,

Eyes: double vision, blurry vision, cataracts, eye pain, visual change

ENT: hearing loss, sore throat, hoarseness, swallowing difficulty, nose bleeds, sinus infection

Cardiovascular: chest pain, palpitations, high blood pressure, lightheadedness, CHF, leg edema

Respiratory: shortness of breath, increased sputum production, wheezing, persistent cough

Gastrointestinal: Irritable bowel syndrome , constipation, diarrhea, reflux/heart burn, food intolerance, blood in stool

Genitourinary: urgency, frequency, burning, incontinence, blood in urine,

Musculoskeletal: back pain, neck pain, joint pain/swelling, muscle pain,

Skin: rash, lesions, skin cancers

Neurological: headache, seizure, weakness, numbness, tremor, spasms, balance dysfunction, falls

Psychiatric: depression, anxiety, insomnia, panic attacks, bipolar disorder

Endocrine: diabetes, low blood sugar, heat intolerance, cold intolerance, hair loss,

Hematology/Oncology- cancers, bleeding disorders, easy bruising, anemia

Do you drink Alcohol? ☐ No ☐ Yes How many drinks per week? _____

Smoking History: ☐ Current smoker ☐ Former ☐ Never

Have you had any X-rays/MRI/CT scans? Yes NO Where?_____

PAST FAMILY/SOCIAL HISTORY

Marital status ☐ Single ☐ Married ☐ Divorced/separated ☐ Widowed ☐ Life Partner

Currently working? ☐ No ☐ Yes Occupation _____

Exercise Type_____ How Often?_____

FAMILY HISTORY –

	Age if living	Age at Death	Medical condition / cause of death
Father			
Mother			
Brothers; how Many?			
Sisters; how many?			
Children; how many?			

_____

End of Patient Health History. Do not write below this line.

I have reviewed the above information with the patient:

Physician Signature_____Date_____