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: Yes ☐ No ☐

RACE: White☐ Black/African American☐ American Indian/Alaskan Native☐ Asian☐ Other☐

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

—----------**INSURANCE INFORMATION(card will be copied here)**----------

Motor Vehicle or Worker's Compensation Below Only

Insurance Co:_____Claim # _____

Address_____Date of Injury_____

Employer:_____Phone_____

---

* *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 .*

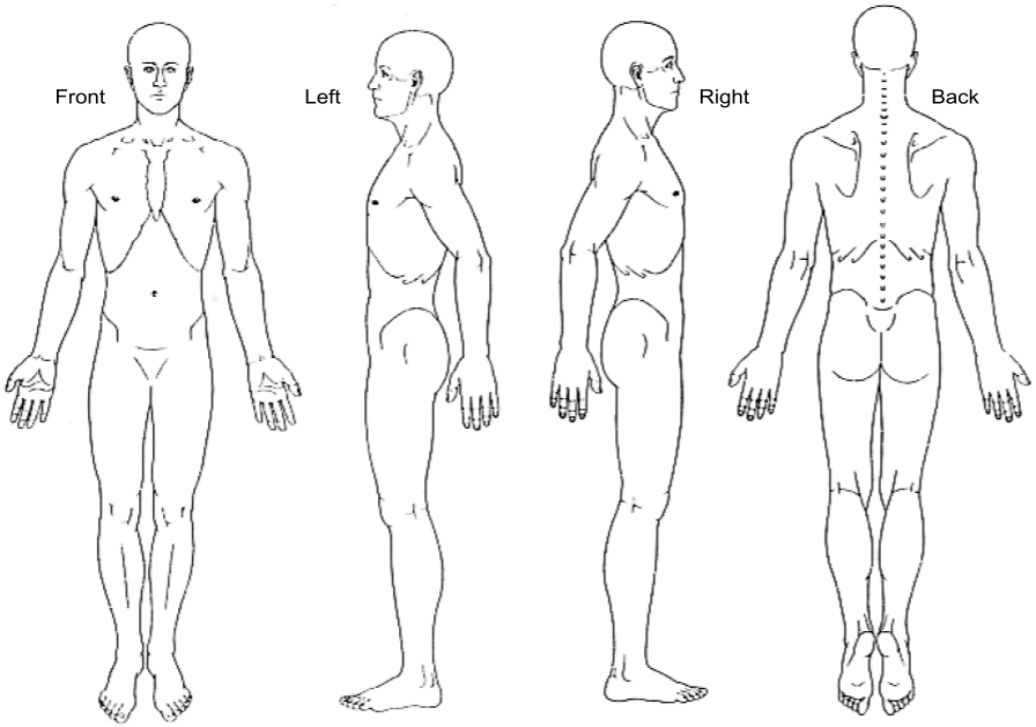
**** PATIENT SIGNATURE*_____DATE_____**

Reason for Appointment:_____

How and when did this problem start?_____

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

*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 the next page.

Using the scale from 0-10 | Circle 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**

Is your pain constant ? Yes No If **No** | how long does an episode last?_____

When during the day is your pain at its worst?_____? When is it at its best? _____

Does it wake you from sleep? Yes No

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 | Driving | Cold weather Movement | Coughing | Sneezing | Lack of Sleep

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

CURRENT MEDICATIONS Please list medication and dosage

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.
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: IBS, constipation, diarrhea, reflux/heartburn, 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

SOCIAL HISTORY:

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

Smoking History: ☐Current smoker ☐Former ☐Never

Have you ever had a problem with **Alcohol or Narcotic medications**? ☐Yes ☐No

If yes please explain._____

FAMILY/SOCIAL HISTORY:

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

Currently working? ☐No ☐Yes Occupation _____ Exercise

Type_____ How Often?_____

FAMILY HISTORY :

Has anyone in your family had a problem with **Alcohol**? ☐Yes ☐No

If yes please explain._____

Has anyone in your family had a problem with **Narcotics**? ☐Yes ☐No

If yes please explain._____

	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**_____