NEUROSURGICAL ASSOCIATES

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Dear Patient,

Welcome to Neurosurgical Associates. We ask that you take some time to complete this questionnaire to the best of your knowledge. This questionnaire will allow the doctor to know more about you, your medical condition, your family and your habits. **We ask that you fill out this form in ink prior to your visit and bring it with you on the date of your appointment.** This questionnaire is confidential and will be kept as part of your medical record. If you have any questions about issues of confidentiality, please feel free to contact our office at (615) 986-1256.

Date of visit: ____________________ Email Address: ____

Patient Name: ____ Date of Birth: __________________________________

Address: ____ SS#: __________________________________

Phone Numbers: (H) ________________________ (W) ________________________(C) __________________________

Check all that apply: Message can be left on □ Home □ Work □ Cell Message may be □ Brief □ Extended

Are you right-handed or left-handed? (Circle One) **Height**: ____________________**Weight**: _______________________

RACE: Please check one (optional)

__American Indian or Alaska Native
__ Black or African American
__Asian
__Hispanic or Latino
__Native Hawaiian or other Pacific
__Other
__White

PRIMARY LANGUAGE:

__Arabic
__French
__Chinese
__Spanish
__English
__Other: ___________

INSURANCE INFORMATION:

Primary Insurance: ____________________________________ Policy #:____

Address:____ Group #:____

Phone: _____________________ Name of Insured: _________________________ DOB __________SSN______________

Employer of Policyholder: ____

Secondary Insurance: ___________________________________ Policy #:____

Address: ____ Group #:____

Phone: _____________________ Name of Insured: _________________________ DOB __________SSN______________

Employer of Policyholder: ____

------OR------

Worker's Compensation

Insurance Carrier: __________________________________ Claim #:_____________________Date of Injury:___________

Address: ____ Employer:____

Phone: ___________________________ Adjustor's Name: _________________________ Phone: _____________________

WHO REFERRED YOU TO OUR OFFICE?

Physician Name: ______________________________________ Specialty: ____

Address: ____

Phone Number: ____ Fax Number: _____________________________________

WHO IS YOUR PRIMARY CARE PHYSICIAN?

O SAME AS REFERRING DOCTOR ABOVE

Physician Name: ______________________________________ Address: ____

Phone Number: ____ Fax Number: _____________________________________

PLEASE LIST ALL OTHER PHYSICIANS WHO SHOULD RECEIVE A COPY OF OUR REPORT:

(1) Name: _____________________________________

Address: ______________________________________

Phone: ____

Fax: ____

(2) Name: _____________________________________

Address: ______________________________________

Phone: ____

Fax: ____

PLEASE LIST BELOW THE NAMES OF ANYONE ELSE THAT YOU WOULD LIKE TO HAVE ACCESS TO YOUR MEDICAL INFORMATION WITH OUR OFFICE:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

I authorize the release of any medical information necessary to process insurance claims. I authorize payment of medical benefits to Neurosurgical Associates.

____________________________________ ________________________________

Patient's or Authorized Signature Date

REVIEW OF SYSTEMS: Please check all conditions that currently apply to you.

GENERAL:

- O Weight loss or gain
- O Chest pain
- O Change in appetite
- O Altered taste or smell
- O Heart murmur
- O Chest pressure
- O Angina
- O Fainting
- O Excessive sleepiness
- O Low blood pressure
- O Unable to sleep
- O Fatigue
- O Leg swelling

EARS, NOSE & THROAT:

- O Mouth sores
- O Vertigo
- O Sinus disease
- O Sore throat
- O Ringing in ears
- O Hearing loss
- O Cataracts
- O Blurred vision
- O Double vision

RESPIRATORY:

- O Shortness of breath
- O Trouble breathing
- O Emphysema
- O Tuberculosis
- O Chronic cough

GENITOURINARY:

- O Sexual dysfunction
- O Impotence
- O Kidney stones
- O Urinary incontinence
- O Urinary urgency
- O Vaginal bleeding
- O Frequent urination
- O Painful urination
- O Blood in urine

PSYCHIATRIC:

- O Anxiety
- O Depression
- O Trouble concentrating

GASTROINTESTINAL:

- O Ulcer
- O Vomiting
- O Constipation
- O Diarrhea
- O Bowel Incontinence
- O Hiatal hernia
- O Reflux
- O Rectal bleeding

NEUROLOGICAL:

- O Headache
- O Seizure
- O Memory loss
- O Loss of consciousness
- O Weakness
- O Falling down
- O Vertigo
- O Concussion

MUSCULOSKELETAL:

- O Low back pain
- O Neck pain
- O Joint pain
- O Trouble walking
- O Joint swelling
- O Numbness

HEMATOLOGICAL:

- O Blood disorder
- O HIV
- O Enlarged lymph nodes
- O Hepatitis
- O Tingling leukemia
- O Sickle cell disease

PAST MEDICAL HISTORY:

O GERD/Heartburn	O Atrial Fibrillation	O Arthritis
O Ulcers	O Pacemaker	O Chronic Back pain
O Colon Polyps	O AICD(Defibrillator)	O Cancer
O Hernia	O COPD	O Kidney Failure
O Pancreatitis	O Diabetes	O Heart Attack
O Ulcerative Colitis	O Thyroid Problems	O Seizures
O Hypertension	O Elevated Cholesterol	O Glaucoma
O Coronary Artery Disease	O Stroke	O Pneumonia
O Congestive Heart Failure	O Fibromyalgia	

PAST SURGICAL HISTORY:

O Colonoscopy	O Hemorrhoidectomy	O Prostate Surgery
O EGD(Upper endoscopy)	O Bypass Surgery	O Back or Neck Surgery
O Ulcer Surgery	O Heart Valve Replacement	O Hip Surgery
O Colon Surgery	O Hysterectomy	O Knee Surgery
O Cholecystectomy	O Ovaries Removed	O Weight Loss Surgery
O Appendectomy	O Breast Cancer Surgery	O Brain Surgery
O Peripheral Nerve Stimulator	O Spinal Cord Stimulator	O Intrathecal Pain Pump
O Other: ________________________		

Have you ever had a problem with anesthesia? O Yes O No
If yes, please explain.____

Have you ever had a blood transfusion? O Yes O No
If yes, why? ____

SOCIAL HISTORY:

Do you drink alcohol? O Yes O No **If yes,** approximately how many drinks per week? ___________________

Do you smoke? O Yes O No **If yes,** how often? O every day O some days **If yes,** how many a day? ________

How soon after you wake do you smoke? _______ Are you interested in quitting? O Yes O Thinking about it O No

What is your occupation?

O Full Time O Part Time O Retired O Homemaker O Student O Unemployed O Disabled

Was the injury due to a work-related accident? O Yes O No

Was the illness/injury caused by an automobile accident? O Yes O No

Was another party responsible for the accident? O Yes O No

Is there any litigation involved? O Yes O No If yes, please explain. __________________________________

FAMILY HISTORY:

O Arthritis	O Hypertension	O Cancer
O Heart Attack	O High Cholesterol	
O Heart Disease	O Diabetes Mellitus	
O Peripheral Vascular Disease	O Stroke	

MEDICATIONS: Please list all medications and dosage you are currently taking, including over the counter medications. Please also include the length of time you have been taking any narcotic medications.

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

7. ______________________________

8. ______________________________

9. ______________________________

10. ______________________________

Do you take aspirin or any medicines that contain aspirin such as Ibuprofen or Motrin? If yes, please specify:
____

PHARMACY: Please provide the name and phone number of your pharmacy so that we may keep this information on file if needed.

Name: ______________________ Phone: ______________________

PAIN MANAGEMENT:

Are you currently in Pain Management or receiving pain medications from another physician? O Yes O No

If yes, please list below the name and address this physician:

Name: __________________ Address: __________________

Phone: __________________ Fax: __________________

ALLERGIES: Please list any known drug and/or food allergies.

1. __________________ 2. __________________

3. __________________ 4. __________________

5. __________________ 6. __________________