**NEUROSURGICAL ASSOCIATES**

**Richard A. Berkman, MD**
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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: _____ Ph: _____ Fax: _____

**WHO IS YOUR PRIMARY CARE PHYSICIAN?** **O SAME AS REFERRING DOCTOR**

Physician Name: _____ Address: _____ Ph: _____

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

1. Physician Name: _____ Address: _____ Ph: _____

2. Physician Name: _____ Address: _____ Ph: _____

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

1. _____ 2. _____

**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

**HISTORY OF PRESENT ILLNESS:**

1. What is the reason for your visit today? _____

2. How long have you had the problem? _____

3. How severe is the problem? _____

4. What type of symptoms are you experiencing? _____

5. How often do your symptoms occur? _____

6. How long do your symptoms last? _____

7. Is there anything that makes the problem worse? _____

8. Does anything make the problem better? _____

9. Have you ever had treatment or surgery for this problem? _____

10. Please rate your pain on a scale from 0 to 10. _____

**PREVIOUS TREATMENT:** Please check all treatments you have tried.

O previous surgery O physical therapy O exercise program O narcotic pain medication (Lortab, Percocet, Vicodin)

O brace O Chiropractor O Anti-inflammatory medications (Motrin, Naproxen, Aspirin)

O wrist splints O Other: _____

O epidural steroid injection(s)____times → These provided relief for: O no relief O1-4 weeks O 5-8 weeks O 8+ weeks

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

**PAST SURGICAL HISTORY:**

O Colonoscopy
O EGD(Upper endoscopy)
O Ulcer Surgery
O Colon Surgery
O Cholecystectomy
O Appendectomy
O Peripheral Nerve Stimulator
O Hemorrhoidectomy
O Bypass Surgery
O Heart Valve Replacement
O Hysterectomy
O Ovaries Removed
O Breast Cancer Surgery
O Spinal Cord Stimulator
O Prostate Surgery
O Back or Neck Surgery
O Hip Surgery
O Knee Surgery
O Weight Loss Surgery
O Brain Surgery
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 Heart Attack
O Heart Disease
O Peripheral Vascular Disease
O Hypertension
O High Cholesterol
O Diabetes Mellitus
O Stroke
O Cancer

**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. _____
7. _____ 8. _____