



NEUROLOGY ASSOCIATES, P.A.

Neurology Associates, PA
Patient Medical History

NA # _____

Name _____ Date of Birth _____ Today's Date _____ Referring Dr. _____

Past Medical History: Check all that you have or have had in the past:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Cancer & (type) _____	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Depression	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sleep Problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Snoring
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Restless Leg Syndrome	Other: _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	

Surgical Procedures and Dates: Check here if you have had no prior surgeries

Pharmacy Name & Location: _____

Medications: (Include prescriptions, over the counter medications, vitamins, & hormones, etc.):

Check here if you take NO medications

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Drug Allergies and Reactions: Check here if you have no known drug allergies

Have you ever had a reaction to IV dye? _____

Family History: Use correct letter(s) to show if an immediate family member has had any of the problems listed:

Mother=M	Grandmother:	Mother's Mother=MGM	Father's Mother=PGM	Sister=S
Father=F	Grandfather:	Mother's Father=MGF	Father's Father=PGF	Brother=B
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Cancer & (type) _____	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sinus Problems	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Sleep Problems	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Snoring	

Social History:

Alcohol Use:	<input type="checkbox"/> Do not use	<input type="checkbox"/> Social drinker	#Drinks/week _____
Caffeine Use:	<input type="checkbox"/> Do not use	<input type="checkbox"/> Use occasionally	#Drinks/week _____
Tobacco Use:	<input type="checkbox"/> Former Smoker	<input type="checkbox"/> Never Smoked	
	<input type="checkbox"/> Smokes	# Packs/Day _____	<input type="checkbox"/> Oral Tobacco
Drug Use:	<input type="checkbox"/> Do not use	<input type="checkbox"/> Marijuana	<input type="checkbox"/> IV drugs
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Education Level:	Other: _____
Occupation:	Employer:		

(Continue on other side of form)



NEUROLOGY

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General Health: Check all that you have had in the past 3 months.

Check here if pregnant

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Problem focusing
<input type="checkbox"/> Fever/Chills	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Constipation	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Disturbing thoughts
<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Postnasal drip	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Shooting pain	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Swallowing problem	<input type="checkbox"/> Change in moles	<input type="checkbox"/> Moodiness
<input type="checkbox"/> Sleep disturbance	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Skin lumps	<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Weight gain/loss	<input type="checkbox"/> Sores in mouth	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Skin rashes	<input type="checkbox"/> Homicidal thoughts
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Blackouts/fainting	<input type="checkbox"/> Change in periods
<input type="checkbox"/> Eye discharge	<input type="checkbox"/> Chest pain at rest	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Speech difficulty	<input type="checkbox"/> Excessive sweating
<input type="checkbox"/> Eye pain/soreness	<input type="checkbox"/> Chest pain/exercise	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Headache/Migraines	<input type="checkbox"/> Problem w/heat/cold
<input type="checkbox"/> Vision loss	<input type="checkbox"/> Blue skin color	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Excessive thirst
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Paralysis/weakness	<input type="checkbox"/> Excessive hunger
<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Bladder control loss	<input type="checkbox"/> Numbness	<input type="checkbox"/> Abnormal bleeding
<input type="checkbox"/> Red eyes	<input type="checkbox"/> Ankle swelling	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Seizures	<input type="checkbox"/> Anemia
<input type="checkbox"/> Swollen eyes	<input type="checkbox"/> Cough/Croup	<input type="checkbox"/> Back pain	<input type="checkbox"/> Tingling	<input type="checkbox"/> Bruising
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Cough up blood	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Tremors	
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Snoring	<input type="checkbox"/> Joint stiffness	<input type="checkbox"/> Anxiety	Females:
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Rapid breathing	<input type="checkbox"/> Limited movement	<input type="checkbox"/> Sleep changes	Last menstrual
<input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Muscle pain/cramps	<input type="checkbox"/> Depression	Period

Sleep Patterns: How likely are you to doze off or fall asleep (not just feel tired) in the following situations?

Never=0 Slight chance=1 Moderate chance=2 High Chance=3
Chance of Dozing

Situation	Never=0	Slight chance=1	Moderate chance=2	High Chance=3
Sitting & reading				
Watching TV				
Sitting inactive in a public place like a theater or meeting				
Riding as a passenger in a car for an hour without a break				
Lying down to rest in the afternoon				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car while stopped for a few minutes				
Column Total				

Average amount of sleep you get most nights _____

Check one: After a full night of sleep, you feel Rested and refreshed or Excessively tired throughout the day.

Do you kick your feet or legs throughout the night? Yes /No

Do you suffer from morning headaches? Yes /No

Do you snore loudly? Yes /No

Do you stop breathing in your sleep? Yes /No

Insomnia Scale: If you have sleep difficulty/insomnia, complete this section:

How many nights a week do you have problems falling asleep or staying asleep? _____

How long have you had this problem? _____

Rate the severity of the following problems in the chart below:

No Problems=0 Mild Problem=1 Moderate Problem=2 Severe Problem=3

Problems falling asleep	_____
Difficulty staying asleep/frequent awakenings	_____
Awakening earlier than you wish	_____
Daytime sleepiness	_____
Poor/impaired function at home or work	_____
Mood swings	_____
Memory loss	_____
Being hyperactive, anxious, or nervous during the day	_____
Column Total	_____

Patient Signature _____



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Patient Name: _____

Authorization for Treatment

I hereby authorize such examinations, treatments, medications, tests, and procedures as may be prescribed by the Neurology Associates, PA physician or physician assistant in charge of my care.

Acceptance of Financial Responsibility

I understand that I am directly responsible for all medical expenses regardless of insurance coverage and whether or not treatment is needed as a result of an accident in which another person is at fault. I understand that I am responsible for any deductibles, co-pays, co-insurance or amounts for services not covered by my insurance carrier.

Assignment of Benefits

I hereby authorize payment by my insurance carrier directly to Neurology Associates, PA for any physician and/or medical services or benefits.

Designation of Personal Representative

I hereby designate the following individual(s) as my personal representative(s) and authorize Neurology Associates, PA to release any verbal or written information about me to my personal representatives as may be needed to assist with my ongoing treatment. This designation and authorization will remain in effect until revoked by me in writing.

<u>Personal Representative Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____

By signing this document I acknowledge that I understand and agree to the foregoing terms and conditions.

_____	_____
(Signature of Patient, Parent or Guardian)	(Date)

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that Neurology Associates, PA will use and disclose my personal health information according to Neurology Associates, PA's Notice of Privacy Practices (the "Notice"). I acknowledge that I have received a copy of the Notice.

_____	_____
(Signature of Patient, Parent or Guardian)	(Date)