ATTENTION NEW PATIENT!

ATTACHED IS THE NEW PATIENT PACKET FOR YOU TO FILL OUT COMPLETELY.

PLEASE BRING YOUR INSURANCE CARD, THIS PACKET AND A REFERRAL (IF YOUR INSURANCE REQUIRES ONE) TO YOUR SCHEDULED APPOINTMENT.

PLEASE **DO NOT** MAIL THIS BACK!

ALSO, IF YOU CANNOT MAKE YOUR APPOINTMENT, PLEASE CALL OUR OFFICE. WE DO HAVE AN OFFICE POLICY IF THE APPOINTMENT ISN'T CANCELLED WITHIN 24 HOURS OR THE PATIENT IS A **NO SHOW**, THERE IS A $50 CHARGE TO THE PATIENT (IF A MINOR, THE PATIENTS PARENTS ARE CHARGED)

UPON RESCHEDULING WE WILL ASK FOR A CREDIT CARD NUMBER OR CHECK TO FULFILL THIS $50 CHARGE. WE WILL NEED THIS PAYMENT BEFORE THE NEW APPOINTMENT IS MADE.

PATIENT PORTAL AUTHORIZATION

Dear Patient,

We are launching a new patient portal for our office. By signing up for the patient portal, you will be able to view your visit summaries and send non-urgent medical questions to our office staff. Please provide your email address so you can be signed up for the portal today.

Patient Name: _____

DOB: _____

Patient Zip Code: _____

Email Address: _____

□ Yes, sign me up for the patient portal.

□ No, I DO NOT want to participate in the patient portal.

For Office Use Only:

Date entered:_____

□ Accepted □ Declined

Initials: ____

Institute of Neurology
200 South Orange Avenue, Suite 165
Livingston, NJ 07039
Phone (973)322-7580
Fax (973-322-7505)

PATIENT MEDICAL QUESTIONAIRE

Name:_____ Date: _____
Address: _____
City: _____ State:_____ Zip: _____
Home Phone: _____ Cell phone: _____

Sex: _____ Age: ____ Date of Birth: _____Email: _____

Physician's Name: _____ Phone: _____
Address: _____
Were you referred by your physician? Yes/No If not, how were you referred?
_____ shall we send a report to your physician? Yes/No

Years of school: 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Marital Status: Single Married Remarried Divorced Widowed Separated
How many years? _____ Number of children: _____ Ages: _____
Primary Occupation: _____ Years: _____
Previous/other occupations, hobbies: _____
Spouse's Occupation: _____
Last worked: _____Are you disabled from work: Yes _____ No _____
Reason: _____

Exposure to hazardous materials: Yes _____ No ____ Type _____

What is the chief problems that brings you here: _____
How long have you had the problem? _____
What do you think might be causing it? _____

PAST MEDICAL HISTORY:

Year	Illness/operations	Place of hospitalization	Do not write here
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

Do you have any of the following:

Abdominal pain?	___ Yes	___ No
Frequent heartburn or indigestion?	___ Yes	___ No
Change in bowel habits?	___ Yes	___ No
Black or bloody bowel movements?	___ Yes	___ No
Difficulty urinating?	___ Yes	___ No
Do you lose control of urine at times?	___ Yes	___ No
Awaken at night more than once to urinate?	___ Yes	___ No
Sexual problems or change in sex drive?	___ Yes	___ No
Do you have any discharge?	___ Yes	___ No

Any changes in skin, moles, rash?	___ Yes	___ No
Persistent painful stiff or swollen joints?	___ Yes	___ No
Back pain or discomfort?	___ Yes	___ No

Do you enjoy your work?	___ Yes	___ No
How many people in your household?	___ Yes	___ No
Any stress or frequent conflict at home?	___ Yes	___ No
Do you feel anxious or depressed?	___ Yes	___ No
Have you seriously considered suicide?	___ Yes	___ No
Difficulty in sleeping?	___ Yes	___ No
History of hospitalization for an emotional problem?	___ Yes	___ No

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Women only:

Are menstrual periods normal?	___ Yes	___ No
Date of last menstrual period?	___ Yes	___ No
Bleeding between periods or after menopause?	___ Yes	___ No
Any "hot flashes?"	___ Yes	___ No
Any pain or dryness with intercourse?	___ Yes	___ No
Any breast discharge?	___ Yes	___ No
Pregnancies____ Deliveries_____ Miscarriages_____ Abortions_____		
Approximate date of last PAP smear?	_____	
Have you used hormones?	___ Yes	___ No

Have you ever had?

___ Asthma	___ Kidney Stones	___ Syphilis
___ AIDS or HIV Testing	___ Bladder Infection	___ Cancer
___ Skin Cancer	___ Kidney Infection	___ Thyroid Trouble
___ Diabetes -Years_____	___ Radiation or Chemotherapy	___ Ulcer
___ Gonorrhea	___ Phlebitis or Blood Clots	___ Tuberculosis
___ Heart Murmur	___ Pneumonia	___ Colon Polyps
___ Heart Attack -Year_____	___ Polio	___ Sexually Transmitted Disease
___ Hepatitis	___ Rheumatic Fever	___ Migraine/Head Pain
___ Herpes	___ Stroke	

Have we left anything out that you are concerned about or feel is important about your health?

Family History: List parents and all siblings. If deceased, please list age of death and cause.

	Living?	Age:	Any known medical conditions or cause of death
Spouse:			
Children:			
Mother:			
Father:			
Sisters:			
Brothers:			

Is there a family history of any of the following in a blood relative, including parents, siblings, aunts, uncles, grandparents, etc.

Stroke	Tuberculosis	Breast Cancer	Kidney disease
Heart surgery	Glaucoma	Colon Polyps	Alcoholism
Aneurysm	Nervous breakdown	Arthritis	Thyroid disease
Liver problems	Kidney stones	Epilepsy	Colon cancer
Diabetes	Kidney failure	Migraine headaches	Asthma/emphysema
High blood pressure	High cholesterol / Triglyceride	Other cancer	Heart attack/angioplasty

Other problems_____

MEDICINES: List all medicines that you have been taking recently. Include all vitamins and non-prescription medicines. Please bring all on day of visit.

Name:	Dose(mg's & times per day)	Date started	Date stopped	Name:	Dose (mg's & times per day)	Date started	Date stopped
1.				5.			
2.				6.			
3.				7.			
4.				8.			

Have you used and "recreational" drugs? ___Yes ___No Kind: _____

ALLERGIES or reactions to medicines or other substances. List all medications and substances.

Name of Medication: Type of Reaction: Date:

_____

_____

_____

_____

IMMUNIZATION/VACCINES and Date:

Pneumonia (pneumovax)_____ Hepatitis _____

Measles _____ BCG _____

Tetanus _____ Flu _____

Other _____

PREVIOUS STUDIES/DATE (Bring copies of recent test and x-ray results)

Chest X-ray _____ Cat Scan Head _____ Bronchoscopy _____

Kidney/IVP_____ Cat scan Other _____ Echocardiogram_____

Stomach/UGI_____ Colon/ Barium Enema _____ MRI _____

Ultrasound of_____ Stress test _____ Protoscopy_____

PERSONAL HABITS:

Tobacco: ___Yes _____ No Have you ever smoked? ___ Yes _____ No

Type and amount _____ Years _____ If stopped, When? _____

Have you tried to stop? _____ Yes _____ No Do you wish to stop? ___Yes ___No

Alcohol: Amount (including beer, wine, and liquor) _____

Have you felt the need to cut down on alcohol?	_____ Yes	_____ No
Do you feel guilty about the amount used?	_____ Yes	_____ No
Have you had a problem with alcohol?	_____ Yes	_____ No
Have you had a drink in the last 24 hours?	_____ Yes	_____ No

Coffee, Tea and Cola Beverages: (amount per day):_____

Travel: (Where and when in the last 2 years): _____

Diet: Any special diets or change in eating habits? _____

Exercise: Any exercise? ___Walking ___ Athletic ___Other _____

Is the purpose of this examination to determine disability status for the government or an insurance company?	_____ Yes	_____ No
Have you had an injury for which there is now a lawsuit pending?	_____ Yes	_____ No

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Do you have any of the following:

Recent weight gain? (amount) _____	_____ Yes	_____ No
Recent weight loss? (amount) _____	_____ Yes	_____ No
Fever or soaking sweats at nights?	_____ Yes	_____ No
Fatigue?	_____ Yes	_____ No

Weakness, numbness, tingling, cramps at night of arms or legs?	_____ Yes	_____ No
New, frequent or severe headaches?	_____ Yes	_____ No
Falls, imbalance or difficulty walking?	_____ Yes	_____ No
Loss of consciousness, fainting or convulsions?	_____ Yes	_____ No
Loss of memory or confusion?	_____ Yes	_____ No

Problem with vision or eyes?	_____ Yes	_____ No
Date of last eye exam?	_____	
Do you wear glasses or contact lenses?	_____ Yes	_____ No
Change in hearing?	_____ Yes	_____ No
Do you use a hearing aid?	_____ Yes	_____ No
Change in speech or voice?	_____ Yes	_____ No
Dizziness? (__ Spinning __ Lightheadedness)	_____ Yes	_____ No
Frequent or severe nosebleeds?	_____ Yes	_____ No
Trouble chewing or swallowing?	_____ Yes	_____ No
Sore tongue or mouth or dental problems?	_____ Yes	_____ No

Daily cough or cough with bloody phlegm?	_____ Yes	_____ No
Short of breath after walking up two flights of stairs or hurrying?	_____ Yes	_____ No
Short of breath when just sitting or reclining?	_____ Yes	_____ No
Discomfort or pain in chest?	_____ Yes	_____ No
Swelling of the ankles every day?	_____ Yes	_____ No