

**WELCOME**

**Confidential Patient Health Record  
Required Patient Information  
Please Print**

Full Name: \_\_\_\_\_ Gender: Male / Female  
 Address: \_\_\_\_\_ Apt #: \_\_\_\_\_  
 City/State: \_\_\_\_\_, IL Zip: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Home / Cell Alt Phone #: \_\_\_\_\_ Cell / Work  
 Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Address: \_\_\_\_\_  
 Physician's Phone #: \_\_\_\_\_ Referred by: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Ph # \_\_\_\_\_ Relationship: \_\_\_\_\_  
*\*If you are not the subscriber on your insurance policy, please complete this section using the Policy Holder's information.*  
 Subscriber's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
 Date of Birth: \_\_\_/\_\_\_/\_\_\_ Subscriber's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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*Office Use: For Insurance Verification please provide both ID and Insurance Card*

**Additional Information****Patient Work Info**

Name of  
 Company \_\_\_\_\_  
 Company Phone # \_\_\_\_\_ Direct Extension \_\_\_\_\_  
 Company Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Spouse Work Info**

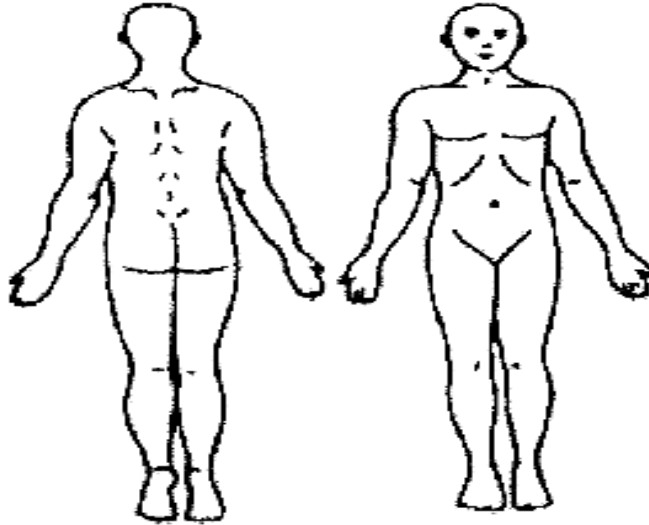
Name of  
 Company \_\_\_\_\_  
 Company Phone # \_\_\_\_\_ Direct Extension \_\_\_\_\_  
 Company Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**CURRENT HEALTH CONDITION**

Chief complaint (Why you are here today): \_\_\_\_\_

**PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT**

Use the letters below to indicate the type and location of your sensations right now:  
A= Ache B= Burning N= Numbness P= Pins and Needles S= Stabbing O= Other



Functional Impairment (Resting)  
0 1 2 3 4 5 6 7 8 9 10

Functional Impairment (with Activity)  
0 1 2 3 4 5 6 7 8 9 10

Pain Rating (Circle One): Minimal Mild Mild- Moderate Moderate Moderate-Severe

When did this condition begin? \_\_\_\_\_

Has it ever occurred before?  Yes  No

Is the condition:  Auto Related  Work Related  No Injury  Other

Explain: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Time of Accident: \_\_\_\_\_

Complaint/Pain Onset Date: \_\_\_\_\_

If Work Related: Have you filed an injury report with your employer?  Yes  No

Claim #: \_\_\_\_\_

Have you seen other Doctors for this condition?  Yes  No

If Yes, Who? (Name): \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Results: \_\_\_\_\_

Doctor's Notes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## REVIEW OF SYSTEMS – Please fill out all of the sections, even if “None”.

### Constitutional:

- |                                      |                                 |   |                                      |                               |
|--------------------------------------|---------------------------------|---|--------------------------------------|-------------------------------|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Chills | <input type="checkbox"/> Daytime Somnolence | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> None |
| <input type="checkbox"/> Fatigue     | <input type="checkbox"/> Fever  | <input type="checkbox"/> Night Sweats       |                                      |                               |

### Eyes/Vision:

- |  |   |                                    |   |  |
|--|---|------------------------------------|---|--|
| <input type="checkbox"/> Glasses/ Contacts | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Change in vision | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Blindness         | <input type="checkbox"/> Field Cuts     | <input type="checkbox"/> Glaucoma  | <input type="checkbox"/> Itching          | <input type="checkbox"/> Photophobia   |
| <input type="checkbox"/> Eye Pain          | <input type="checkbox"/> None           |                                    |   |  |
| <input type="checkbox"/> Tearing           |   |                                    |   |  |

### Ears, Nose and Throat (ENT):

- |   |   |   |  |   |
|---|---|---|--|---|
| <input type="checkbox"/> Tinnitus (Ringing in Ears) | <input type="checkbox"/> Dental Implants          | <input type="checkbox"/> Dentures         | <input type="checkbox"/> Difficulty Swallowing   | <input type="checkbox"/> Discharge        |
| <input type="checkbox"/> Bleeding                   | <input type="checkbox"/> Ear Drainage             | <input type="checkbox"/> Ear Infection(s) | <input type="checkbox"/> Ear Pain                | <input type="checkbox"/> Fainting         |
| <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Head Injury (history of) | <input type="checkbox"/> Hearing Loss     | <input type="checkbox"/> Hoarseness              | <input type="checkbox"/> Loss of Smell    |
| <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Nose bleeds (frequent)   | <input type="checkbox"/> Post Nasal Drip  | <input type="checkbox"/> Rhinorrhea (Runny nose) | <input type="checkbox"/> Sinus Infections |
| <input type="checkbox"/> Nasal Congestion           | <input type="checkbox"/> Sore Throats (frequent)  | <input type="checkbox"/> TMJ problems     | <input type="checkbox"/> None                    |   |
| <input type="checkbox"/> Snoring                    |   |   |  |   |

### Respiration:

- |  |                                 |                                |  |  |
|--|---------------------------------|--------------------------------|--|--|
| <input type="checkbox"/> Wheezing          | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Sputum Production | <input type="checkbox"/> None   |                                |  |  |

### Cardiovascular:

- |   |                                    |                                       |  |                                       |
|---|------------------------------------|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Varicose Veins   | <input type="checkbox"/> Angina    | <input type="checkbox"/> Chest Pain   | <input type="checkbox"/> Claudication                  | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Heart Problems   | <input type="checkbox"/> Orthopnea | <input type="checkbox"/> Palpitations | <input type="checkbox"/> SOB with Exertion or Exercise |                                       |
| <input type="checkbox"/> Swelling of Legs | <input type="checkbox"/> Ulcers    | <input type="checkbox"/> PND          | <input type="checkbox"/> None                          |                                       |

### Gastrointestinal:

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> Abdominal Pain             | <input type="checkbox"/> Belching        | <input type="checkbox"/> Black, Tarry Stools              | <input type="checkbox"/> Constipation   | <input type="checkbox"/> Diarrhea             |
| <input type="checkbox"/> Difficulty Swallowing      | <input type="checkbox"/> Heartburn       | <input type="checkbox"/> Hemorrhoids                      | <input type="checkbox"/> Indigestion    | <input type="checkbox"/> Jaundice             |
| <input type="checkbox"/> Nausea                     | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Abnormal Stool Caliber (quality) | <input type="checkbox"/> Vomiting Blood | <input type="checkbox"/> Abnormal Stool Color |
| <input type="checkbox"/> Abnormal Stool Consistency |  | <input type="checkbox"/> Vomiting                         |   | <input type="checkbox"/> None                 |

### Female:

- |  |   |  |   |   |
|--|---|--|---|---|
| <input type="checkbox"/> Birth Control   | <input type="checkbox"/> Breast Lumps/Pain      | <input type="checkbox"/> Burning Urination | <input type="checkbox"/> Cramps           | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Hormone Therapy | <input type="checkbox"/> Irregular Menstruation | <input type="checkbox"/> Urine Retention   | <input type="checkbox"/> Vaginal Bleeding | <input type="checkbox"/> Vaginal Discharge  |
| <input type="checkbox"/> None            |   |  |   |   |

### Male:

- |  |   |   |  |  |
|--|---|---|--|--|
| <input type="checkbox"/> Burning Urination | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Hesitancy/Dribbling | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Urine Retention   | <input type="checkbox"/> None                 |   |  |  |

### Endocrine:

- |   |                                   |   |   |  |
|---|-----------------------------------|---|---|--|
| <input type="checkbox"/> Cold Intolerance   | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Excessive Appetite | <input type="checkbox"/> Excessive Hunger | <input type="checkbox"/> Excessive Thirst    |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Goiter   | <input type="checkbox"/> Hair Loss          | <input type="checkbox"/> Heat Intolerance | <input type="checkbox"/> Unusual Hair Growth |
| <input type="checkbox"/> Voice Changes      | <input type="checkbox"/> None     |   |   |  |

### Skin:

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Changes in Nail Texture   | <input type="checkbox"/> Changes in Skin Color | <input type="checkbox"/> Hair Growth  |
| <input type="checkbox"/> Hair Loss                 | <input type="checkbox"/> Itching               | <input type="checkbox"/> Paresthesia  |
| <input type="checkbox"/> History of Skin Disorders | <input type="checkbox"/> Skin Lesions/Ulcers   | <input type="checkbox"/> Varicosities |
|  |  | <input type="checkbox"/> Rash         |
|  |  | <input type="checkbox"/> None         |

### Nervous System:

- |   |  |                                    |   |  |
|---|--|------------------------------------|---|--|
| <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Facial Weakness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Limb Weakness        | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Numbness        | <input type="checkbox"/> Seizures  | <input type="checkbox"/> Sleep Disturbance    | <input type="checkbox"/> Slurred Speech        |
| <input type="checkbox"/> Stress         | <input type="checkbox"/> Strokes         | <input type="checkbox"/> Tremors   | <input type="checkbox"/> Unsteadiness of Gait |  |

### Psychologic:

- |                                     |   |   |   |                                    |
|-------------------------------------|---|---|---|------------------------------------|
| <input type="checkbox"/> Anxiety    | <input type="checkbox"/> Appetite Changes | <input type="checkbox"/> Behavioral Change(s) | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Insomnia         | <input type="checkbox"/> Memory Loss          | <input type="checkbox"/> Mood Change(s)   | <input type="checkbox"/> None      |

### Allergy:

- |                                      |   |                                  |   |                                   |
|--------------------------------------|---|----------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Food Intolerance | <input type="checkbox"/> Itching | <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> None        |   |                                  |   |                                   |

### Hematology:

- |                                 |                                   |   |   |                                   |                                  |  |                               |
|---------------------------------|-----------------------------------|---|---|-----------------------------------|----------------------------------|--|-------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Blood Clotting | <input type="checkbox"/> Blood Transfusion(s) | <input type="checkbox"/> Bruising | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Lymph Node Swelling | <input type="checkbox"/> None |
|---------------------------------|-----------------------------------|---|---|-----------------------------------|----------------------------------|--|-------------------------------|

**PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.**

**Childhood Illness:**

- |  |  |  |  |   |
|--|--|--|--|---|
| <input type="checkbox"/> ADD                 | <input type="checkbox"/> Allergies/Hay fever | <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Atopic Dermatitis | <input type="checkbox"/> Bedwetting       |
| <input type="checkbox"/> Cerebral Palsy      | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Depression                    | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Ear Infections   |
| <input type="checkbox"/> Fetal Drug Exposure | <input type="checkbox"/> Food Allergies      | <input type="checkbox"/> Headaches                     | <input type="checkbox"/> Hepatitis         | <input type="checkbox"/> Spina Bifida     |
| <input type="checkbox"/> Measles             | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Rash                          | <input type="checkbox"/> Scoliosis         | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Sickle Cell Anemia  | <input type="checkbox"/> None                | <input type="checkbox"/> Other(please describe): _____ |  |   |

**Adult Illness:**

- |  |   |   |  |   |
|--|---|---|--|---|
| <input type="checkbox"/> Anemia                                    | <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Chicken Pox            |
| <input type="checkbox"/> Crohn's/Colitis                           | <input type="checkbox"/> CRPS (RSD)             | <input type="checkbox"/> CVA (Stroke)       | <input type="checkbox"/> Depression          | <input type="checkbox"/> Diabetes (Insulin Dep) |
| <input type="checkbox"/> Diabetes (NIDDM)                          | <input type="checkbox"/> Diabetes (Non insulin) | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Eye Problems        | <input type="checkbox"/> Fibromyalgia           |
| <b>Heart Disease</b>   | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> HIV                | <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Kidney Disease         |
| <input type="checkbox"/> Liver Disease                             | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Psychiatric Problems   |
| <input type="checkbox"/> Scoliosis                                 | <input type="checkbox"/> STD'S                  | <input type="checkbox"/> Suicide Attempt(s) | <input type="checkbox"/> Thyroid Problems    |   |
| <input type="checkbox"/> Vertigo                                   | <input type="checkbox"/> None                   |   |  |   |
| <input type="checkbox"/> Other Illness (please be specific): _____ |   |   |  |   |

**Surgeries:**

- |   |  |   |  |   |
|---|--|---|--|---|
| <input type="checkbox"/> Angioplasty            | <input type="checkbox"/> Appendectomy  | <input type="checkbox"/> Caesarian Section                | <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> Carpal Tunnel Repair |
| <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Cosmetic      | <input type="checkbox"/> D & C                            | <input type="checkbox"/> Dental Surgery          | <input type="checkbox"/> Gallbladder          |
| <input type="checkbox"/> Hemorrhoidectomy       | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Hysterectomy                     | <input type="checkbox"/> Joint Reconstruction    | <input type="checkbox"/> Joint Replacement    |
| <input type="checkbox"/> Laminectomy            | <input type="checkbox"/> Mastectomy    | <input type="checkbox"/> Pacemaker Insertion              | <input type="checkbox"/> Rotator Cuff            | <input type="checkbox"/> Spinal Fusion        |
| <input type="checkbox"/> Tonsilectomy           | <input type="checkbox"/> None          | <input type="checkbox"/> Other (please be specific) _____ |  |   |

**Menstrual History:**

My menses is:  Regular  Irregular  Menopause  Done

**Injuries: Describe: \_\_\_\_\_**

None

**Non-Drug Allergies Describe: \_\_\_\_\_**

None

**Family History**

	Alive	Deceased	Condition (please be specific)
General Family	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Maternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	_____
Maternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Son (s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Daughter (s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother (s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister (s)	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Social History**

**Alcohol:**  Never  Social Consumption only

**Drugs:**  Denies any  Denies use of IV drugs  Have not used drugs since \_\_\_\_\_  Have used drugs for \_\_\_\_\_

**Tobacco:** Type \_\_\_\_\_ Amount \_\_\_\_\_

Are you currently taking any prescription medications?  Yes  No. If yes, please mark or list below (be specific).

- |   |   |  |                                  |  |
|---|---|--|----------------------------------|--|
| <input type="checkbox"/> Allergy Medication | <input type="checkbox"/> Anti-Depressants | <input type="checkbox"/> Blood Pressure Medication         | <input type="checkbox"/> Insulin | <input type="checkbox"/> Muscle Relaxers |
| <input type="checkbox"/> Nerve Pills        | <input type="checkbox"/> Pain Killers     | <input type="checkbox"/> Other (please be specific): _____ |                                  |  |

Do you wear a shoe lift?  Yes  No

Please list any other conditions you feel we should know about – even if unrelated: \_\_\_\_\_

**I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_, and I AUTHORIZE, REQUEST, AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.**

**SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

**NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE**

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

For any YES answer, please notify the Doctor

- |   |    |     |
|---|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?<br>Comment: _____    | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?<br>Comment: _____ | NO | YES |
| 3. Do your hands or arms fall asleep regularly?<br>Comment: _____                               | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?<br>Comment: _____ | NO | YES |
| 5. Do you suffer from a loss of handgrip strength?<br>Comment: _____                            | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?<br>Comment: _____     | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?<br>Comment: _____  | NO | YES |
| 8. Do your legs or feet fall asleep regularly?<br>Comment: _____                                | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?<br>Comment: _____    | NO | YES |
| 10. Do you suffer from cold hands or feet?<br>Comment: _____                                    | NO | YES |
| 11. Do you suffer from headaches, dizziness or memory loss?<br>Comment: _____                   | NO | YES |
| 12. Do you have difficulty maintaining your balance?<br>Comment: _____                          | NO | YES |
| 13. Do you suffer from vertigo or blurred vision?<br>Comment: _____                             | NO | YES |
| 14. Do you suffer from a reduced hearing capacity?<br>Comment: _____                            | NO | YES |
| 15. Do you suffer from ringing in your ears?<br>Comment: _____                                  | NO | YES |
| 16. Do you have a bladder or bowel control problems on a regular basis?<br>Comment: _____       | NO | YES |

Note: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form maybe shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.