UPPER VALLEY NEUROLOGY NEUROSURGERY, PC

106 Hanover Street, Lebanon, NH 03766 Phone: 603.448.0447 Fax: 603.448.0019

Neurology
Donald W. Ayres, M.D.
President
Board Certified in Neurology
Added Qualification in Clinical Neurophysiology
ASN Certified in Neuroimaging – MRI & CT
Certified Physician Clinical Trial Investigator

Neurosurgery-Emeritus
Richard L. Saunders, M.D.
Board Certified in Neurological Surgery
Added Qualification in Cervical Spine

Neurosurgery
Joseph M. Phillips, M.D., Ph.D.
Board Certified in Neurological Surgery
Harold J. Pikus, M.D.
Board Certified in Neurological Surgery
Darrin Michalak, PA-C
Board Certified by NCCPA
Hulda B. Magnadottir, M.D.
Board Certified in Neurological Surgery
Alyssa M. Pearl, PA-C
Board Certified by NCCPA
Patrick A. Schembri, PA-C
Board Certified by NCCPA

Administration
Meredith Underhill, MBA, LPN
Practice Manager

Name _____

Address_____

City, State, Zip Code _____

Please complete all pages of this medical history form before reporting for your examination.

DOB: _____ **Age**: _____ **Sex**: M F **Handedness**: L R (circle)

Height: _____ **Current Weight**: _____

For what problem are you being referred to this office:

_____

_____

Do you believe that this problem is work related: Yes, No, If yes, explain:

_____

Did this problem begin after an injury: Yes, No, If yes what kind of injury:

_____

The problem is (circle) : constant comes and goes improved worse

_____

_____

_____

Medical history: Do you have any of the following medical conditions:

CONDITION	YES	NO	YEAR DIAGNOSED	WHAT TYPE
High blood pressure				
High cholesterol				
Depression				
Diabetes				
Asthma				
Ulcers				
Irregular heart rate				
Migraine headaches				
Seizures/Epilepsy				
Arthritis				
Lung disease				
Kidney disease				
Thyroid disease				
Skin disease				
Liver/Intestine disease				
Cancer				

Do you have Heart Disease? Yes or No What Type:_____
Cardiologist:_____ Last Cardiology Appt:_____
Other Conditions:_____
_____

Have you ever had any of the following?

CONDITION	YES	NO	WHEN (YEAR)		
Heart Attack					
Heart Bypass Surgery					
Neck Injury					
Back Injury					
Stroke					
Head Injury				Did you black out?	Yes or No
Car Accident				Did you black out?	Yes or No

Please list all previous surgeries that you have had.

1) _____ When? _____ Where? _____

2) _____ When? _____ Where? _____

3) _____ When? _____ Where? _____

4) _____ When? _____ Where? _____

5) _____ When? _____ Where? _____

6) _____ When? _____ Where? _____

Social history:

Occupation: (if retired, list previous job) _____

Tobacco use: ( ) Never smoked cigarettes/cigar
( ) Used to smoke _____ packs per day but quit in (year) _____
( ) Currently smoke _____ packs per day, started smoking at age _____

Do you use: Chewing Tobacco - Y/N E-Cigarette - Y/N Vaporizer - Y/N

Alcohol use: ( ) Have never used alcohol ( ) Drink occasionally ( ) Drink daily
( ) Quit drinking in: _____
( ) I usually drink (circle) beer wine mixed drinks
And I usually have _____ drinks in one day.

Family history:

Are you adopted? Y/N

Mother: ( ) Alive ( ) Deceased Age ___ Cause of death if deceased: _____
Father: ( ) Alive ( ) Deceased Age ___ Cause of death if deceased: _____
Age of brothers: _____ _____ _____ If deceased, indicate age at time: _____
Age of sisters: _____ _____ _____ If deceased, indicate age at time: _____
Age of children: _____ _____ _____

Do/did any of these family members have any of the following medical conditions:

CONDITION	**YES**	**NO**	**WHO** (Mother, Father, Sister, Brother, Etc.)
High blood pressure			
Migraine Headaches			
Alzheimer's disease			
Multiple sclerosis			
Heart Attack			
Diabetes			
Seizures			
Tremors			
Stroke			
Carpal tunnel syndrome			

Other Conditions: _____
Who: _____

Medications

Allergies: Please list medications that you are allergic to:

_____

_____

Please list seasonal or environmental allergies:

_____

Current Medications: Please list all your current medications and supplements with dosages and how you take them. (Option: Attach medication list from your pharmacy.)

Medication	Dosage	Taken	Why do you take it?
Example: Advil	200mg	2 tablets every 8 hours	Pain

Form Completed by: _____Date:____/_____/____
Reviewed with patient by: _____Date:____/____/____

Review of Symptoms: For the following symptoms, please place a check mark "√" next to those you currently experience and circle any that have been a problem in the past.

Constitutional

__Fever
__Chills
__Headache
__Feeling Poorly (Malaise)
__Feeling Tired (Fatigue)
__Recent Weight Gain (___lbs)
__Recent Weight Loss (___lbs)

Eyes

__Eye Pain
__Red Eyes
__Eyesight Problems
__Discharge from Eyes
__Dry Eyes
__Eyes Itch

ENT

__Earache
__Loss of Hearing
__Nosebleeds (Epistaxis)
__Nasal Discharge
__Sore Throat
__Hoarseness

Cardiovascular

__Chest Pain
__Palpitations
__Heart Rate is Fast
__Heart Rate is Slow
__Leg Claudication

Respiratory

__Shortness of Breath
__Wheezing
__Cough
__Labored Breath (Dyspnea on Exertion)
__Short of Breath Lying Down (Orthopnea)
__Shortness of Breath that Awakens at Night (PND)

Gastrointestinal

__Abdominal Pain
__Vomiting
__Constipation
__Diarrhea
__Heartburn
__Dark Stool (Melena)

Genitourinary

__Painful Urination (Dysuria)
__Incontinence
__Hesitancy
__Nighttime Urination (Nocturia)
__Testicular Pain
__Genital Lesion
__Pelvic Pain
__Menstrual Cramps(Dysmenorrhea)
__Vaginal Discharge
__Abnormal Vaginal Bleeding

Musculoskeletal

__Joint Pain (Arthralgia)
__Muscle Pain
__Joint Swelling
__Joint Stiffness
__Limb Pain
__Limb Swelling

Integumentary

__Skin Lesions
__Skin Wound
__Dry Skin
__Itching (Pruritus)
__Change in a Mole
__An Unusual Growth
__Breast Pain
__Breast Lump

Neurological

__Confused
__Convulsions
__Dizziness
__Fainting (Syncope)
__Limb Weakness (Paresis)
__Difficulty Walking

Psychiatric

__Suicidal
__Sleep Disturbances
__Anxiety
__Depression
__Change in Personality
__Emotional Problems

Endocrine

__Bulging Eyes (Proptosis)
__Hot Flashes
__Muscle Weakness
__Erectile Dysfunction
__Deepening of the Voice
__Feelings of Weakness

Hematologic/Lymphatic

__Easy Bleeding
__Easy Bruising
__Swollen Glands
__Swollen Glands in the Neck

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Administration
Kimberly McKinney Office Manager
Meredith Underhill, LPN Clinical Support Manager

PATIENT INFORMATION

Patient name _____ **Date of birth**_____

Mailing address (If PO Box, please also provide Physical Address)

_____

Please circle the best number to reach you:
Home Work Cell

Home phone _____

Work phone _____ Social Security # _____

Cell Phone _____ Marital Status _____

Race: (Please circle)
White
American/Alaskan Indian
Black/African American
Asian
Native Hawaiian/Pacific Islander
Other
Declined

Ethnicity: (Please circle)
Hispanic/Latino
Non Hispanic/Latino
Declined

Language:
_____
or
Declined

Would you be interested in our patient portal?
Yes No

Email Address:_____

Employer _____ Phone _____
Employer address
_____

Primary care doctor _____ Phone _____

Referring doctor _____ Phone _____

Preferred Pharmacy _____ City/State _____

Person to notify in case of an emergency, their phone number and relation to you:

_____

Do you have: Living Will Yes No
Durable Power of Attorney for Healthcare Yes No

GUARANTOR INFORMATION

Who carries the insurance? ________________________DOB:_________________

SSN#: ______________________Their relationship to you**:** _________________

Employer and address which insurance is through

____

PLEASE HAVE RECEPTIONIST TAKE A COPY OF YOUR INSURANCE CARD.

DOES YOUR INSURANCE REQUIRE A REFERRAL?
If so, did you get one? Please let the receptionist know.

I authorize payment of medical benefits to Upper Valley Neurology Neurosurgery, PC for all services rendered. I understand I am financially responsible for any balances not fully paid by my insurance company.

I hereby authorize the release of my medical information related to these claims to my insurance company.

Signature **_____________________________________** ***Date*** **_________**

****

If you are being seen due to an accident at work please complete the following:

ACCIDENT/WORKERS COMPENSATION INFORMATION

Date of accident:_________________ **Claim #:**___________________________

Is this a workers compensation injury? (If yes, please indicate **place of employment** in which the accident occurred, their **address**, and **phone number**.)

____

____

____

Workers compensation/Liability insurance name, address and phone number:

____

____

Provider ______________

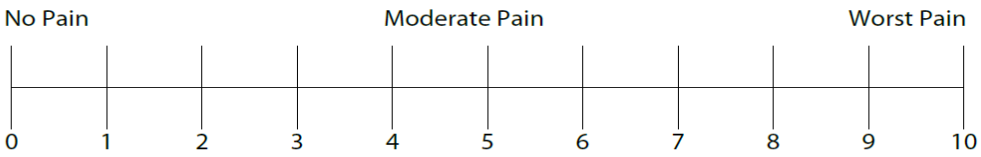
Name:

Upper Valley Neurology Neurosurgery

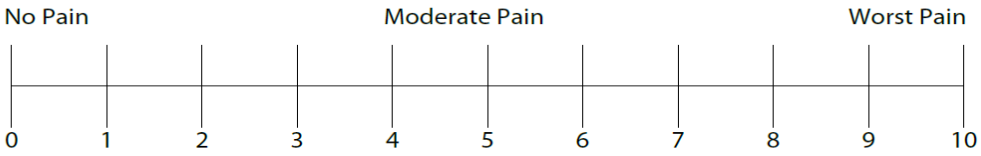
DOB:

Date _________________

Shade in the area where you experience pain.



Please rate your pain by circling the one number below that describes your pain at its worst.



What activities or positions seem to make your pain worse (ex, walking, sitting, standing)?

What makes your pain better (ex, sitting, walking, lying)?

What treatments have been tried to improve your pain?

Physical Therapy	Pain medication
Chiropractic treatments	Muscle relaxants
Epidural steroid injections	Anti-Inflammatory

What of the above treatments improved your pain or made in better?

What current medications are you taking for pain?