ROCHESTER NEUROSURGERY PARTNERS

Today's Date: ____________________

G. Edward Vates, MD, PhD
Catherine Hastings, ANP-C

PATIENT MEDICAL HISTORY

Patient Information:

Patient Name: ____
(First) (Middle) (Last)

Home Address: ____
(Street Name and #) (City, State) (Zip)

Phone Numbers: ____
(Home) (Business) (Cell)

Demographic Information:

Date of Birth: _____/_____/_____ (mm dd yyyy) Age _______ Sex: ☐M / ☐ F

Social Security #: _______-______-_______ Marital Status: ____________________

Physician Information:

Referring Physician: ______________________ Phone #: ______________

Address: ____

Primary Care Physician: ______________________ Phone #: ______________

Address: ____

Insurance Information:

Primary Carrier: ______________________ Phone #: ______________

Subscriber's Name: ______________________ Subscriber's DOB: _____/_____/_____ (mm dd yyyy)

Subscriber's Social Security #: _____-_____-_____ Relationship: ______________

Policy or Subscriber ID: ____

Secondary Carrier: ______________________ Phone #: ______________

Subscriber's Name: ______________________ Subscriber's DOB: _____/_____/_____ (mm dd yyyy)

Subscriber's Social Security #: _____-_____-_____ Relationship: ______________

Policy or Subscriber ID: ____

Worker's Comp / MVA Insurance Carrier: ____

Address: ____

Carrier Case #: ______________________ WCB/Policy #: ______________

Date of Injury: _____/_____/_____ (mm dd yyyy) Carrier Phone #: ______________

Last Day Worked: _____/_____/_____ (mm dd yyyy)

Preferred Pharmacy:

Pharmacy Name: ______________________ Pharmacy Phone #: ______________

Pharmacy Fax #: ______________

Pharmacy Address: ____

University of Rochester Neurosurgery Group

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize University of Rochester Neurosurgery Group to release information to any hospital of physician to whom I may be referred. I also authorize University of Rochester Neurosurgery group to release information requested by my insurance company or Worker's Compensation carrier.

SIGNATURE:____ DATE:________________

RELATIONSHIP TO PATIENT:____

INSURANCE AUTHORIZATION

I understand that it is my responsibility to provide up-to-date information on my insurance and request that payment of authorized benefits are made on my behalf to the University of Rochester Neurosurgery Group for any and all services rendered to me by this practice. If my insurance carrier does not cover these services, I understand that I will be financially responsible.

SIGNATURE:____ DATE:________________

RELATIONSHIP TO PATIENT:____

MEDICARE SIGNATURE ON FILE (if applicable)

I certify that the information given to me in applying for payment under title XVIII of the Social Security Act is correct. I authorize this office to release my medical information to the Social Security Administration or its carriers, or any information required to process my Medicare claims. I request that payment under the medical insurance program be made to the University of Rochester Neurosurgery Group for services provided to me.

SIGNATURE:____ DATE: ________________

RELATIONSHIP TO PATIENT:____

New Patient Information Sheet

G. Edward Vates, MD, PhD | Laura Calvi, MD
Catherine Hastings, ANP-C | Ismat Shafiq, MD

Multidisciplinary Neuro-Endocrine Clinic

Patient Name:________________________ Date of Birth:________________

Primary care Physician: ________________________ Referring Physician:________________

Address:________________________ Phone:________________

Please describe the reason of your visit: ________________________

Symptoms:

When did symptoms begin? ________________________

When does the pain/problem occur (i.e.: morning/night):________________________

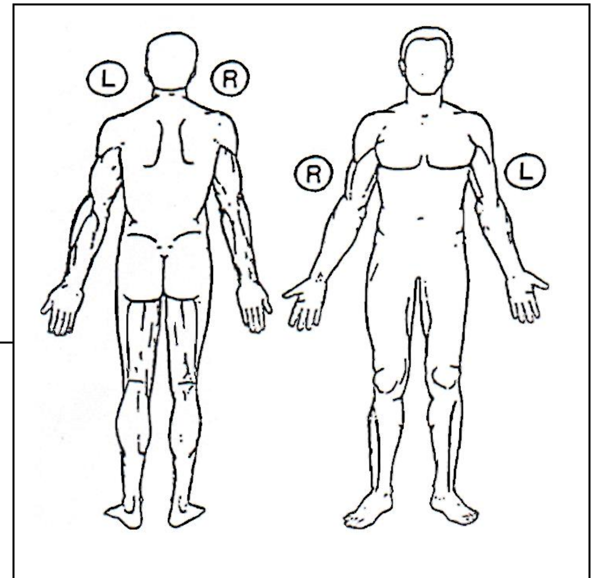
What aggravates the symptoms:________________________

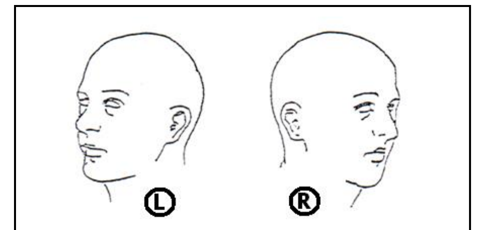
What reduces the symptoms:________________________

Place check if you have other symptoms:

Symptom		Occurrence	Location
☐	Numbness	☐ Constant ☐ Intermittent	
☐	Pins/Needles/Tingling	☐ Constant ☐ Intermittent	
☐	Sharp pain	☐ Constant ☐ Intermittent	
☐	Dull/Achy pain	☐ Constant ☐ Intermittent	

Shade the areas you have pain:





Rate your Pain:

Pain Scale: 0=No Pain 10=Worst Pain: Today________Past Week ________

Please check current or previous therapy:

Types of Therapy		Effect on your symptoms	Month/Year
☐	Physical Therapy	☐ Better ☐ Worse ☐ No Change	
☐	Nerve Blocks	☐ Better ☐ Worse ☐ No Change	
☐	Medication Use	☐ Better ☐ Worse ☐ No Change	
☐	Chiropractor	☐ Better ☐ Worse ☐ No Change	
☐	Other	☐ Better ☐ Worse ☐ No Change	

DISABILITY STATUS	Yes	No	TYPE
Are you currently on disability?	☐	☐	
Have you applied for disability?	☐	☐	
Last Day you worked:			

Is this injury a result of: **Motor Vehicle Accident?** ☐ **Yes** ☐ **No**
Work-Related Injury? ☐ **Yes** ☐ **No**

Date of Injury:________________

If you answered "yes" to either of the above, explain how the injury occurred: ________________________

____

ALLERGIES: ☐ **NONE**

List all known allergies to **medication, food, or latex**

NAME OF MEDICATION/FOOD/LATEX	TYPE OF REACTION

Have you ever had reaction to any dye given during a special test? ________If so, what was the test? ____________________

What was the reaction? ____

CURRENT MEDICATION

List all medications you are taking ☐ **NO MEDICATIONS**

(Include over the counter, vitamins, and herbs)

NAME OF MEDICATION	DOSE/MG	FREQUENCY

NAME OF MEDICATION	DOSE/MG	FREQUENCY

MEDICAL HISTORY

List all medical problems for which you are currently being treated (high blood pressure, diabetes, heart disease, etc.)

MEDICAL PROBLEM

MEDICAL PROBLEM

SURGICAL HISTORY ☐ **NO HOSPITALIZATIONS**

List all surgical procedures or major hospitalizations and year of occurrence

YEAR	REASON FOR HOSPITALIZATION

YEAR	REASON FOR HOSPITALIZATION

FAMILY HISTORY

List pertinent family history (diabetes, heart disease, cancer, etc.)

PARENTS	AGE	LIVING	DECEASED	MAJOR ILLNESS/CAUSE OF DEATH
Father				
Mother				
Siblings				

SOCIAL HISTORY

Occupation: ______________________ **If retired, list previous occupation:** ______________________

Employer: ____

Marital Status:
☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** **Number of children:** _______

Who do you live with? ______________________

Highest grade of school completed:
☐ **Elementary** ☐ **High School** ☐ **College** ☐ **Post Graduate**

Alcohol Use: ☐ **None**
Amount:_________ **per:** ☐ **Days** ☐ **Months** ☐ **Years**

Tobacco Use: ☐ **None**
__________**Packs/Cigars a day for** _________**# of years.** **Quit smoking** __________ **years ago.**

Street Drug Use: ☐ **None**
Type: ______________ **Frequency:** __________ ☐ **Days** ☐ **Weeks** ☐ **Months** ☐ **Years**
Date of last use: ________________

REVIEW OF SYSTEMS: Please place **check if you have or had** problems related to the following systems.

	General	Comments
☐	Unexplained Weight Loss	
Eyes/Ears		
☐	Double/Blurred Vision	
☐	Hearing Loss	
☐	Cataracts	
Pulmonary		
☐	Asthma	
☐	COPD/Emphysema	
☐	Sleep Apnea	
☐	Pneumonia in past year	
☐	Shortness of Breath with exertion	
Cardiovascular		
☐	High Blood Pressure	
☐	Heart Attack	
☐	Pacemaker/AICD	
☐	Valve Disease	
☐	Chest Pain	
☐	Congestive Heart Failure	
Gastrointestinal		
☐	Heartburn/Indigestion/Reflux	
☐	Bowel Incontinence	
☐	Liver Disease/Hepatitis	
☐	Ulcers	

	Genitourinary	Comments
☐	Incontinence/Retention	
☐	Prostate Enlargement	
Musculoskeletal		
☐	Arthritis/Location	
Endocrine		
☐	Diabetes	
☐	Thyroid	
Hematological		
☐	Blood Clots	
☐	Hemophilia	
☐	Von Willebrand's Disease	
Neurological		
☐	Seizures	
☐	TIA/Stroke	
Psychiatric		
☐	**Depression/Anxiety**	
Other		
☐		
Cardiac/Pulmonary Testing		
☐	Stress Test	
☐	Heart Angiogram	
☐	Echocardiogram	
☐	Pulmonary Function Test	

Person Completing Form (please print): ______________________ Signature: ______________________

Date: ______________________

ENDOCRINE REVIEW

Please complete to the best of your ability:

CONSTITUTIONAL:

- Good appetite? ☐ Yes ☐ No
- Fever/Chills? ☐ Yes ☐ No
- Night sweats? ☐ Yes ☐ No
- Unintentional weight loss? ☐ Yes ☐ No
- Unintentional weight gain? ☐ Yes ☐ No
- Excessive fatigue? ☐ Yes ☐ No

Comments: ____________________

EYES:

- Dryness? ☐ Yes ☐ No
- Persistent redness? ☐ Yes ☐ No
- Loss of vision? ☐ Yes ☐ No
- Visual disturbances? ☐ Yes ☐ No
- Irritation? ☐ Yes ☐ No

Comments: ____________________

EARS/NOSE/THROAT:

- Hearing loss? ☐ Yes ☐ No
- Ringing in ears? ☐ Yes ☐ No
- Nosebleeds? ☐ Yes ☐ No
- Chronic sinus congestion? ☐ Yes ☐ No
- Heavy snoring? ☐ Yes ☐ No
- Change in voice? ☐ Yes ☐ No

Comments: ____________________

RESPIRATORY:

- Cough? ☐ Yes ☐ No
- Phlegm/sputum production? ☐ Yes ☐ No
- Wheezing? ☐ Yes ☐ No
- Shortness of breath? ☐ Yes ☐ No

Comments: ____________________

CHEST/VASCULAR:

- Chest discomfort or pressure? ☐ Yes ☐ No
- Palpitations? ☐ Yes ☐ No
- Leg swelling? ☐ Yes ☐ No
- Calf or buttock pain with walking? ☐ Yes ☐ No
- Fainting? ☐ Yes ☐ No

Comments: ____________________

GASTROINTESTINAL:

- Change in appetite? ☐ Yes ☐ No
- Difficulty swallowing? ☐ Yes ☐ No
- Nausea/Vomiting? ☐ Yes ☐ No
- Heartburn/Indigestion? ☐ Yes ☐ No
- Abdominal pain? ☐ Yes ☐ No
- Diarrhea? ☐ Yes ☐ No
- Constipation? ☐ Yes ☐ No
- Blood in stool/Black stool? ☐ Yes ☐ No

Comments: ____________________

GENITOUROLOGIC:

- Urination at night? ☐ Yes ☐ No
- Frequent urination? ☐ Yes ☐ No
- Burning with urination? ☐ Yes ☐ No
- Blood in urine? ☐ Yes ☐ No
- Incomplete emptying? ☐ Yes ☐ No
- Leakage of urine? ☐ Yes ☐ No
- Sexual problems? ☐ Yes ☐ No
- Decreased libido? ☐ Yes ☐ No
- Change in periods? ☐ Yes ☐ No

Comments: ____________________

MUSCULOSKELETAL:

- Persistent or severe neck pain? ☐ Yes ☐ No
- Persistent or severe back pain? ☐ Yes ☐ No
- Persistent or severe joint pain? ☐ Yes ☐ No
- Muscle pain or cramping? ☐ Yes ☐ No

Comments: ____________________

SKIN/BREASTS:

- Rash? ☐ Yes ☐ No
- Itching? ☐ Yes ☐ No
- Growths? ☐ Yes ☐ No
- New or changing moles? ☐ Yes ☐ No
- Breast lumps? ☐ Yes ☐ No
- Nipple discharge? ☐ Yes ☐ No

Comments: ____________________

NEUROLOGICAL:

- Frequent or severe headaches? ☐ Yes ☐ No
- Falls? ☐ Yes ☐ No
- Numbness/Tingling? ☐ Yes ☐ No
- Tremor? ☐ Yes ☐ No
- Involuntary movement? ☐ Yes ☐ No
- Muscle weakness? ☐ Yes ☐ No
- Memory loss? ☐ Yes ☐ No
- Dizziness? ☐ Yes ☐ No

Comments: ____________________

PSYCHOLOGICAL:

- Anxiety/Nervousness? ☐ Yes ☐ No
- Panic? ☐ Yes ☐ No
- Feeling sad or depressed? ☐ Yes ☐ No
- Insomnia? ☐ Yes ☐ No

Comments: ____________________

ENDOCRINE:

- Cold/Heat intolerance? ☐ Yes ☐ No
- Hot flashes? ☐ Yes ☐ No
- Excessive thirst? ☐ Yes ☐ No

Comments: ____________________

HEMATOLOGY/LYMPH:

- Excessive Bruising? ☐ Yes ☐ No
- Easy Bleeding? ☐ Yes ☐ No
- Swollen Nodes? ☐ Yes ☐ No

Comments: ____________________

ALLERGIES/IMMUNOLOGY:

- Severe allergic reactions? ☐ Yes ☐ No
- Hives? ☐ Yes ☐ No
- Frequent infections? ☐ Yes ☐ No

Comments: ____________________