

NEUROSURGICAL ASSOCIATES

www.tennesseeneurosurgery.com

Dear Patient,

Welcome to Neurosurgical Associates. We ask that you take some time to complete this questionnaire to the best of your knowledge. This questionnaire will allow the doctor to know more about you, your medical condition, your family and your habits. **We ask that you fill out this form prior to your visit and bring it with you on the date of your appointment.** This questionnaire is confidential and will be kept as part of your medical record. If you have any questions about issues of confidentiality, please feel free to contact our office at (615) 986-1256.

Date of visit: _____ Email Address: _____

Patient Name: _____

Date of Birth: _____ SS#: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: (H) _____ (W) _____ (C) _____

Spouse's Name: _____ D.O.B: _____ SS#: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Policy #: _____

Address: _____ Group #: _____

Phone: _____ Name of Insured: _____ DOB _____

Employer of Policyholder: _____

Secondary Insurance: _____ Policy #: _____

Address: _____ Group #: _____

Phone: _____ Name of Insured: _____ DOB _____

Employer of Policyholder: _____

Worker's Compensation

Insurance Carrier : _____ Claim#: _____

Date of Injury: _____ Address: _____

Employer of Policyholder: _____

Phone: _____ Adjuster's Name: _____

WHO REFERRED YOU TO OUR OFFICE?

Physician Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Specialty: _____

PLEASE LIST ALL OTHER PHYSICIANS WHO SHOULD RECEIVE A COPY OF OUR REPORT:

(1) Name: _____

Address: _____

Phone: _____ Fax: _____

(2) Name: _____

Address: _____

Phone: _____ Fax: _____

Are you right-handed or left-handed? (Circle One) Height: _____ Weight: _____

HISTORY OF PRESENT ILLNESS:

1. What is the reason for your visit today?

2. How long have you had the problem? _____

3. How severe is the problem? _____

4. What type of symptoms are you experiencing? _____

5. How often do your symptoms occur? _____

6. How long do your symptoms last? _____

7. Is there anything that makes the problem worse? _____

8. Does anything make the problem better? _____

9. Have you ever had treatment or surgery for this problem? _____

10. Please rate your pain on a scale from 0 to 10. _____

PREVIOUS TREATMENT: Please circle all treatments that you have tried.

Physical Therapy	Tens Unit	Cervical Traction	Chiropractor
Corset/Brace	Oral Steroids	Epidural Sterioid Injection	Trigger Point Injection
Neurontin/Lyrica	Other: _____		

REVIEW OF SYSTEMS: Please circle all conditions that currently apply to you.

GENERAL:

Weight loss or gain	Chest pain	Change in appetite	Altered taste or smell
Chest pressure	Angina	Excessive sleepiness	Fainting
Unable to sleep	Leg swelling	Fatigue	High blood pressure
Low blood pressure	Heart murmur	Heart failure	

EARS, NOSE AND THROAT:

Vertigo	Mouth sores	Sinus disease	Sore throat
Ringing in ears	Hearing loss	Blurred vision	Double vision
Glaucoma	Cataracts		

RESPIRATORY:

Shortness of breath	Trouble breathing	Emphysema	COPD
Tuberculosis	Chronic cough	Pneumonia	

GASTROINTESTINAL:

Ulcer	Vomiting	Constipation	Diarrhea
Bowel incontinence	Gastritis	Hiatal hernia	Rectal bleeding

GENITOURINARY PSYCHIATRIC:

Impotence	Kidney stones	Depression	Anxiety
Sexual dysfunction	Urinary urgency	Urinary incontinence	Vaginal bleeding
Frequent urination	Painful urination	Blood in urine	Trouble concentrating

NEUROLOGICAL:

Headache	Seizure	Loss of consciousness	Memory loss
Weakness	Vertigo	Falling down	Concussion

MUSCULOSKELETAL:

Low back pain	Neck pain	Joint pain	Trouble walking
Numbness	Joint swelling		

ENDOCRINE:

Diabetes	Thyroid disease
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HEMATOLOGICAL:

Blood disorder	HIV	Enlarged lymph nodes	Hepatitis
Leukemia	Sickle cell disease		

PAST MEDICAL HISTORY:

Please list all previous and current problems/major illnesses including approximate dates.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PAST SURGICAL HISTORY:

Please list all operations including approximate dates.

1. _____
2. _____
3. _____
4. _____
5. _____

Have you ever had a problem with anesthesia? _____ If yes, please explain.

Have you ever had a blood transfusion? _____ If yes, why? _____

MEDICATIONS:

Please list all medications and dosage you are currently taking, including over the counter medications.

1. _____
2. _____
3. _____
4. _____
5. _____

Do you take aspirin or any medicines that contain aspirin such as Ibuprofen or Motrin?

If yes, please specify. _____

ALLERGIES:

Please list any known drug and/or food allergies.

1. _____
2. _____
3. _____

FAMILY HISTORY:

Please list all known medical problems for immediate family members. If deceased, please list the cause and approximate age of death.

- 1. _____
- 2. _____
- 3. _____
- 4. _____

SOCIAL HISTORY:

Do you smoke? _____ If yes, how much and for how long? _____

If you quit, approximately how long ago? _____

Do you drink alcohol? _____ If yes, approximately how many drinks per week?

What is your occupation? _____

Are you disabled? _____

Was the injury due to a work-related accident? _____

Was the illness/injury caused by an automobile accident? _____

Was another party responsible for the accident? _____

Is there any litigation involved? _____ If yes, please explain. _____

I authorize the release of any medical information necessary to process insurance claims. I authorize payment of medical benefits to Neurosurgical Associates.

Patient's or Authorized Signature

Date