

New Patient Intake Form

Date: _____

I. Demographic Information

Name: _____ Date of Birth: _____ Age: _____ **SSN#** _____

Home Address: _____

Home phone: _____ Cell Phone: _____

Emergency Contact: _____ **Phone:** _____

II. Care Information – please list complete name and address of physicians (VERY IMPORTANT)

Primary Care Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Referring Physician (if different from PCP): _____ **Specialty:** _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Release of Information (HIPPA Privacy Act) (Valid until otherwise told different)

Who may we leave medical information with? Spouse ___ Children ___ Other ___

Where may we leave medical information? Home answering Machine ___ Cell Phone ___ Other _____

III. Reason for visit – Chief Complaint (History of Present Illness)

Please describe the major problem that brings you in today to see a Neurologist:

Is this visit related to worker's compensation? (circle one) Yes No

Is this visit related to any legal actions? (circle one) Yes No

If this problem is the result of an accident, when did the accident occur? _____

Physician Initials _____

IV. Surgical History

Please list all operations you have had:

Date:

V. Medical History

Please list all active medical conditions:

Duration:

Please list all **MEDICATIONS** you take routinely, prescribed or over-the-counter, along with the dosages:

Medication:

Dose:

Frequency:

Please **LIST** all allergies and sensitivities (e.g. medications, foods, latex, iodine, etc.)

Are you taking any "blood thinning" medications? Yes – indicate below No

Aspirin or aspirin-containing medication

Anti-inflammatory medication

Plavix

Coumadin

Fish Oil

Other: _____

VI. Social History

Occupation: _____ Marital Status: _____ Number of children: _____

Do you smoke cigarettes? _____ If so, how many packs a day? _____

At what age did you start? _____ If applicable, at what age did you stop? _____

Do you drink alcohol? _____ If yes, how much daily? _____

At what age did you start? _____ If applicable, at what age did you stop? _____

Do you use recreational drugs? _____ Type? _____

Do you exercise regularly? (circle one) Yes No How frequently? _____

Weight: _____

Height: _____

Females: Are you, or could you be pregnant? (circle one) Yes No

VII. Family History Do you have a family member affected with:

Condition	Yes	No	type/affected relative	Condition	Yes	No	type/affected relative
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>		Muscle Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	
Dementia	<input type="checkbox"/>	<input type="checkbox"/>		Other Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Parkinson's Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>		Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Write other conditions	_____						

VIII. Review of Symptoms Do you currently, or have you had a problem with:

<u>Constitutional:</u>	<u>Circle One</u>	<u>Endocrine:</u>	<u>Circle One</u>
Fever	Yes No	Diabetes	Yes No
Weight loss >5 lbs	Yes No	Thyroid disease	Yes No
Excessive fatigue	Yes No	Excessive thirst/urination	Yes No
History of Falls	Yes No	<u>Genitourinary:</u>	
<u>Eyes:</u>		Urinary tract infections	Yes No
Wear glasses	Yes No	Painful urination	Yes No
Infections	Yes No	Blood in your urine	Yes No
Injuries	Yes No	Difficult starting/stopping stream	Yes No
Glaucoma	Yes No	Incontinence	Yes No
Cataracts	Yes No	Kidney stones	Yes No
<u>Ear, Nose, Throat & Mouth:</u>		<u>Musculoskeletal:</u>	
Wear hearing aid(s)	Yes No	Broken bones	Yes No
Hearing loss	Yes No	Arm or leg weakness	Yes No
Ear pain/infections	Yes No	Arm or leg pain	Yes No
Ringing in ears	Yes No	Joint pain or swelling	Yes No
Nose bleeds	Yes No	Arthritis	Yes No
Nasal congestion/drainage	Yes No	<u>Integumentary:</u>	
Inability to smell	Yes No	Skin disease	Yes No
Sinus problems	Yes No	Breast pain, tenderness, nipple discharge	Yes No
Balance (vertigo, spinning, etc.)	Yes No	Unusual moles	Yes No
<u>Cardiovascular:</u>		<u>Neurological:</u>	
Chest pain or angina	Yes No	Fainting spells or "black outs"	Yes No
High blood pressure	Yes No	Headaches	Yes No
Irregular pulse	Yes No	Seizures	Yes No
Heart murmur	Yes No	Problems with memory	Yes No
High cholesterol	Yes No	Disorientation	Yes No
Swelling in hands or feet	Yes No	Difficulty with speech	Yes No
Leg pain while walking	Yes No	Inability to concentrate	Yes No
<u>Respiratory:</u>		Double or blurred vision	Yes No
Asthma	Yes No	Weakness in arms and/or legs	Yes No
Emphysema	Yes No	Loss of sensation	Yes No
Shortness of breath	Yes No	Difficulty with balance	Yes No
Pneumonia	Yes No	<u>Psychiatric:</u>	
Bloody sputum	Yes No	Anxiety	Yes No
<u>Gastrointestinal:</u>		Depression	Yes No
Nausea	Yes No	<u>Hematologic/Lymphatic:</u>	
Vomiting	Yes No	Anemia	Yes No
Blood in your vomit	Yes No	Hemophilia	Yes No
Liver disease	Yes No	Blood transfusion	Yes No
Jaundice	Yes No	Persistent swollen glands/lymph nodes	Yes No
Abdominal pain	Yes No	HIV	Yes No
Change in bowel habits	Yes No	<u>Allergic/Immunologic:</u>	
Ulcers or gastritis	Yes No	Food, Inhalant (nasal) allergies	Yes No
		Autoimmune disease (i.e., lupus)	Yes No

VII. Pain Assessment

Do you experience pain as part of your daily life? (circle one) Yes No

If yes, please describe the location(s), onset, duration, and characteristics of your pain:

If yes, on a scale of 1 to 10 (0 = no pain, 10 = the worst pain), how would you rate your pain? _____

VIII. History of Falls

Have you had any significant falls in the past 6 months? Yes No

If yes, please explain: _____

I HEREBY AUTHORIZE LEON BARKODAR, M.D. TO FURNISH TO THE PROVIDED INSURANCE COMPANIES ALL INFORMATION WHICH THE INSURANCE COMPANIES MAY REQUEST. I HEREBY ASSIGN DR. BARKODAR ALL BASIC AND MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED FOR MEDICAL EXPENSES RELATED TO THE SERVICES RENDERED, BUT NOT TO EXCEED INDEBTEDNESS THAT IS DUE. I UNDERSTAND THAT MONEY RECEIVED FROM THE INSURANCE COMPANIES WILL BE REFUNDED WHEN MY BILL IS PAID IN FULL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE SAID DOCTOR FOR CHARGES NOT COVERED BY THE INSURANCE COMPANIES.

(Attention Medicare Patients: Certain tests may not be covered by Medicare. By signing below, you are agreeing that you are choosing to have any test(s) done whether today or in the future. This is called an "Advanced Beneficiary Notice". You may however, decline to do any tests.)

Patient Signature _____

Date: _____

The information on this form is accurate to the best of my knowledge:

Patient Signature

Date completed

I have reviewed the above information with the patient:

Physician Signature

Date reviewed