PATIENT REGISTRATION FORM

NOVA Neurology Center

PATIENT INFORMATION

Last Name	First Name MI	Gender □ Male □ Female
Social Security Number	Date of Birth	Marital Status □ M □ S □ W □ D □ SEP
Race	Ethnicity □ Hispanic □ non-Hispanic	Language (if other than English)
Home Address	E-Mail Address	Pharmacy Name and Address
	Home Phone	
City State Zip	Cell Phone	Pharmacy Phone
Employer Name and Address	Work Phone	Emergency Contact Name
	Primary Care Physician Name	Emergency Contact Relationship
	Referring Physician Name	Emergency Contact Phone

INSURANCE INFORMATION

Primary Insurance Name	Secondary Insurance Name
Member ID #	Member ID #
Subscriber Name and Date of Birth	Subscriber Name and Date of Birth
Relationship to Patient □ Self □ Spouse □ Child □ Other	Relationship to Patient □ Self □ Spouse □ Child □ Other

RESPONSIBLE PARTY/GUARANTOR INFORMATION (IF DIFFERENT FROM PATIENT)

Last Name	First Name MI	Gender □ Male □ Female
Social Security Number	Date of Birth	Relationship to patient
Address		Phone Number

DISCLOSURE TO FAMILY MEMBERS AND FRIENDS

Please list any person that you would like to grant permission to your provider to discuss your Medical Record, Billing Record and Plan of Care

Full Name	Relationship	Home Phone	Cell Phone
Full name	Relationship	Home Phone	Cell Phone

Patient's Signature _____ Date _____

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HEALTH HISTORY QUESTIONARE

Name (Last, First, MI)	Date of Birth
Reason for Today's Visit	

LIST YOUR PRESCRIBED MEDICATIONS, OVER-THE-COUNTER MEDICATIONS AND SUPPLEMENTS

Name	Strength	Frequency

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

ALLERGIES

Name	Reaction you had	Severity
		□ Mild □ Moderate □ Severe
		□ Mild □ Moderate □ Severe
		□ Mild □ Moderate □ Severe
		□ Mild □ Moderate □ Severe
		□ Mild □ Moderate □ Severe

SURGERIES

Type of Surgery (and Reason)	Place of Surgery	Year of Surgery

OTHER HOSPITALIZATIONS

Reason	Name of Hospital	Year of Hospitalization

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FAMILY HEALTH HISTORY

Relationship	Age	Significant Health Problems	Relationship	Age	Significant Health Problems
Father			Child	□ M □ F	
Mother			Child	□ M □ F	
Sibling	□ M □ F		Child	□ M □ F	
Sibling	□ M □ F		Child	□ M □ F	
Sibling	□ M □ F		Grandfather (Paternal)		
Sibling	□ M □ F		Grandmother (paternal)		
Sibling	□ M □ F		Grandfather (maternal)		
Sibling	□ M □ F		Grandmother (maternal)		

SOCIAL HISTORY AND SUBSTANCE USE

Alcohol	What is your level of alcohol consumption? □ None □ Occasional □ Moderate □ Heavy	Tobacco	Have you ever smoked tobacco? □ Y □N
			How many years? _____ Year quit_____
	How many times per week do you consume alcohol?	Type of tobacco	□ Cigarettes _____ pks/day □ E-Cigarettes ____ times/day
			□ Chew _____times/day □ Other _____

Drugs	Have you ever used any illicit or recreational drugs? □ Y □N	If yes, Name of drug :
	Have you ever used IV drugs □ Y □ N	

WOMEN ONLY

Are you pregnant or breastfeeding? □ Y □N	Number of pregnancies:	Number of live birth:

SYMPTOMS EXPERIENCED IN THE PAST 6 MONTHS (CHECK ALL THAT APPLY)

Neurological
- □ Headache
- □ Dizziness/Vertigo
- □ Slurred speech
- □ Imbalance/Unsteady gait
- □ Falls
- □ Abnormal movements
- □ Tremor
- □ Memory loss
- □ Numbness/Tingling
- □ Weakness
- □ Seizure
- □ Cramps/Spasms
- □ Episodes of confusion
- □ Burning/electric pain

General
- □ Fevers
- □ Chills
- □ Night sweats
- □ Excessive fatigue
- □ Weight gain/loss
- □ Trouble sleeping
- □ Trouble staying asleep
- □ Vivid dreams

Throat/Sinus
- □ Nasal congestion
- □ Sinus pain
- □ Nose bleeds

Eyes/Ears
- □ Vision loss
- □ blurred vision
- □ Eye pain
- □ Double vision
- □ Hearing loss
- □ Ringing in ears

Psychiatric
- □ Depression
- □ Anxiety
- □ High levels of stress
- □ Hallucinations
- □ Uncontrollable laugh/crying
- □ Difficulty Concentrating
- □ Hallucination

Cardiac
- □ Chest pain
- □ Palpitation
- □ Loss of consciousness/Fainting
- □ Heart murmur

Urinary
- □ Frequency
- □ Incontinence
- □ Urgency
- □ Incomplete bladder emptying

Neck
- □ Neck pain/stiffness
- □Swollen lymph nodes

Musculoskeletal
- □ Joint pain
- □ Joint swelling
- □ Muscle aches
- □ Muscle twitching

Vascular
- □ Leg swelling
- □ Easy bruising/bleeding
- □ Varicose veins

GI
- □ Swallowing difficulty
- □ Constipation
- □ Diarrhea

Pulmonary
- □ Shortness of breath
- □ Dry cough
- □ Productive cough

Patient Name: _____ **DOB:** _____

PATIENT HEALTH QUESTIONNAIRE

Over the last two weeks, how often have you been bothered by any of the following?

1. Little interest or pleasure in doing things			
□ Not at all	□ Several days	□ More than half the days	□ Nearly every day
2. Feeling down, depressed, or hopeless			
□ Not at all	□ Several days	□ More than half the days	□ Nearly every day
3. Trouble falling or staying asleep, or sleeping too much			
□ Not at all	□ Several days	□ More than half the days	□ Nearly every day
4. Feeling tired or having little energy			
□ Not at all	□ Several days	□ More than half the days	□ Nearly every day
5. Poor appetite or overeating			
□ Not at all	□ Several days	□ More than half the days	□ Nearly every day
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down			
□ Not at all	□ Several days	□ More than half the days	□ Nearly every day
7. Trouble concentrating on things, such as reading the newspaper or watching television			
□ Not at all	□ Several days	□ More than half the days	□ Nearly every day
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual			
□ Not at all	□ Several days	□ More than half the days	□ Nearly every day
9. Thoughts that you would be better off dead or of hurting yourself in some way			
□ Not at all	□ Several days	□ More than half the days	□ Nearly every day

FALL RISK ASSESSMENT (aged 65 and older)

Do you feel unsteady when standing or walking?	□ Yes	□No
Do you worry about falling?	□ Yes	□No
Have you fallen in past year?	□ Yes	□No
If yes: How many times did you fall? _____ Were you injured?	□ Yes	□No