

NASHVILLE NEUROSURGERY ASSOCIATES

Date of visit: _____ Email Address: _____

Patient Name: _____

Date of Birth: _____ SS#: _____ Sex: ___Female ___Male

Address: _____

City: _____ State: _____ Zip _____

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

Check all that apply: Message can be left on H W C Message may be: Brief Extended

Height: _____ ft. _____ in. Weight: _____ lbs. Hand Dominance: Right Handed Left Handed

RACE: Please check one (optional)

- American Indian or Alaska Native
- Asian
- Native Hawaiian or other Pacific
- Black or African American
- White
- Hispanic or Latino
- Other _____
- Declined to Answer

PRIMARY LANGUAGE:

- English
- Arabic
- French
- Other: _____
- Spanish
- Chinese
- Italian

Marital status: Married Widowed Separated Divorced Single Partnership

HEALTH INSURANCE INFORMATION:

Primary Insurance: _____ Policy #: _____

Address: _____ Group #: _____

Phone: _____ Name of Insured: _____ DOB _____ SSN _____

Employer of Policyholder: _____

Secondary Insurance: _____ Policy #: _____

Address: _____ Group #: _____

Phone: _____ Name of Insured: _____ DOB _____ SSN _____

Employer of Policyholder: _____

-----OR-----

Are your symptoms due to a work-related accident? Yes No

WORKER'S COMPENSATION INFORMATION:

Insurance Carrier: _____ Claim #: _____ Date of Injury: _____

Address: _____ Employer: _____

Phone: _____ Adjustor's Name: _____ Phone: _____

Patient Name: _____ DOB: _____

WHO REFERRED YOU TO OUR OFFICE?

Physician Name: _____ Specialty: _____

Address: _____

Phone Number: _____ Fax Number: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN?

SAME AS REFERRING DOCTOR ABOVE

Physician Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

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

[For Example: Cardiologist, Endocrinologist, Oncologist or Pulmonologist]

(1) Name: _____

(2) Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

PLEASE LIST ANY OTHER PERSONS YOU WISH TO HAVE ACCESS TO YOUR MEDICAL INFO:

[For Example: Family, Friends or Attorney]

I authorize Nashville Neurosurgery Associates to contact and discuss my Personal Health Information with the following persons:

1. _____

4. _____

2. _____

5. _____

3. _____

6. _____

X _____
Patient Signature

Date

Patient Name: _____

DOB: _____

REVIEW OF SYSTEMS:

Please check all conditions that applies to you now OR in the past 6 months:

GENERAL:

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

EARS, NOSE & THROAT:

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

RESPIRATORY:

- Shortness of breath
- Trouble breathing
- Emphysema
- Tuberculosis
- Chronic cough

GENITOURINARY:

- Sexual dysfunction
- Impotence
- Kidney stones
- Urinary incontinence
- Urinary urgency
- Vaginal bleeding
- Frequent urination
- Painful urination
- Blood in urine

PSYCHIATRIC:

- Anxiety
- Depression
- Trouble concentrating

GASTROINTESTINAL:

- Ulcer
- Vomiting
- Constipation
- Diarrhea
- Bowel Incontinence
- Hiatal hernia
- Reflux
- Rectal bleeding

NEUROLOGICAL:

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

MUSCULOSKELETAL:

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

HEMATOLOGICAL:

- Blood disorder
- HIV
- Enlarged lymph nodes
- Hepatitis
- Tingling leukemia
- Sickle cell disease

Patient Name: _____

DOB: _____

PAST MEDICAL HISTORY:

- | | | |
|--|--|--------------------------------------|
| <input type="radio"/> GERD/Heartburn | <input type="radio"/> AICD (Defibrillator) | <input type="radio"/> Cancer |
| <input type="radio"/> Colon Polyps | <input type="radio"/> COPD | <input type="radio"/> Kidney Failure |
| <input type="radio"/> Pancreatitis | <input type="radio"/> Diabetes | <input type="radio"/> Heart Attack |
| <input type="radio"/> Ulcerative Colitis | <input type="radio"/> Thyroid Problems | <input type="radio"/> Seizures |
| <input type="radio"/> Hypertension | <input type="radio"/> Elevated Cholesterol | <input type="radio"/> Glaucoma |
| <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Stroke | <input type="radio"/> Pneumonia |
| <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Fibromyalgia | <input type="radio"/> Aneurysm |
| <input type="radio"/> Atrial Fibrillation | <input type="radio"/> Arthritis | |
| <input type="radio"/> Pacemaker | <input type="radio"/> Chronic Back pain | |

PAST SURGICAL HISTORY:

- | | | |
|---|---|---|
| <input type="radio"/> Colonoscopy | <input type="radio"/> Heart Valve Replacement | <input type="radio"/> Hip Surgery |
| <input type="radio"/> EGD (Upper endoscopy) | <input type="radio"/> Hysterectomy | <input type="radio"/> Knee Surgery |
| <input type="radio"/> Ulcer Surgery | <input type="radio"/> Ovaries Removed | <input type="radio"/> Weight Loss Surgery |
| <input type="radio"/> Colon Surgery | <input type="radio"/> Breast Cancer Surgery | <input type="radio"/> Brain Surgery |
| <input type="radio"/> Cholecystectomy | <input type="radio"/> Spinal Cord Stimulator | <input type="radio"/> Intrathecal Pain Pump |
| <input type="radio"/> Appendectomy | <input type="radio"/> Prostate Surgery | <input type="radio"/> Other: _____ |
| <input type="radio"/> Hemorrhoidectomy | <input type="radio"/> Back Surgery | |
| <input type="radio"/> Bypass Surgery | <input type="radio"/> Neck Surgery | |

Have you ever had a problem with anesthesia? Yes No

If yes, please explain:

Have you ever had a blood transfusion? Yes No

If yes, why?

FAMILY HISTORY:

- | | | |
|---|---|------------------------------------|
| <input type="radio"/> Arthritis | <input type="radio"/> Hypertension | <input type="radio"/> Cancer |
| <input type="radio"/> Heart Attack | <input type="radio"/> High Cholesterol | <input type="radio"/> Aneurysm |
| <input type="radio"/> Heart Disease | <input type="radio"/> Diabetes Mellitus | <input type="radio"/> Other: _____ |
| <input type="radio"/> Peripheral Vascular Disease | <input type="radio"/> Stroke | |

Patient Name: _____ DOB: _____

SOCIAL HISTORY:

Do you drink alcohol? Yes No
If yes, approximately how many drinks per week? _____

Do you smoke or vape? Yes No
If yes, how often? every day some days **If yes**, how many a day? _____
How soon after you wake do you smoke? _____
Are you interested in quitting? Yes No Undecided
If you are a former smoker, how long has it been since you last smoked?
 1-3 months 3-6 months 6-12 months 1-5 years 5-10 years 10+ years

Work Status: Full Time Part Time Retired Homemaker Student Unemployed Disabled

Occupation: _____

MEDICATIONS:

Please list all medications and dosage you are currently taking, including over the counter medications.
Please also include the length of time you have been taking any narcotic medications.

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

Do you take aspirin or any medicines that contain aspirin such as Ibuprofen or Motrin? If yes, please specify:

PHARMACY:

Please provide the name and phone number of your pharmacy so that we may keep this information on file if needed.

Name: _____ City: _____ Phone: _____

Patient Name: _____ DOB: _____

PAIN MANAGEMENT:

Are you currently in Pain Management or receiving pain medications from another physician? Yes No

If **yes**, please list below the name and address this physician:

Name: _____ Address: _____

Phone: _____ Fax: _____

ALLERGIES:

Please list any known drug and/or food allergies.

Medication / Food	Type of Reaction

Patient Agreement for Prescribed Medications

I will submit to random pill counts and urine and/or blood drug tests as requested by my provider in order to monitor my treatment. I understand that the presence of any unauthorized substances may prompt referral for assessment of addiction and could result in discontinuation of further opioid and all other prescriptions. I also understand that failure to follow these rules may lead to dismissal from care by my provider.

I will not share, sell or otherwise permit others to have access to my medication and I will keep it in a secure location as I understand that medications reported as lost or stolen will not be refilled early.

By signing this document either in person or electronically, I voluntarily give my consent to prescription medication therapy and fully understand my responsibilities.

X _____
Patient Signature

Date

Patient Name: _____ DOB: _____

HISTORY OF PRESENT ILLNESS:

What is the reason for your visit today?

How long have you had the problem?

How severe is the problem?

What type of symptoms are you experiencing?

How often do your symptoms occur?

How long do your symptoms last?

Is there anything that makes the problem worse?

Does anything make the problem better?

Have you ever had treatment or surgery for this problem?

Please rate your pain on a scale from one to ten. (1 being minor and 10 being severe)

1 2 3 4 5 6 7 8 9 10

PREVIOUS TREATMENT: (Check all that you have tried)

- Previous Surgery
- Physical Therapy
- Exercise Programs
- Chiropractor
- Brace or Wrist Splints
- Narcotic Pain Medication (Lortab, Percocet, Vicodin, Etc.)
- Anti-Inflammatory Medications (Motrin, Naproxen, Aspirin, Etc.)
- Steroidal Anti-Inflammatory Medications (Medrol Dose Pak, Depo-Medrol, Solu-Medrol, Etc.)
- Epidural Steroid Injections:

How many times (number of injections)? _____ These provided relief for:

- No Relief
- 1 – 4 weeks relief
- 5 – 8 weeks relief
- 8+ weeks relief

Patient Name: _____ DOB: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Social Security # _____

I request and authorize _____

to release healthcare information of the patient named above to:

NASHVILLE NEUROSURGERY ASSOCIATES – The office of:

	Provider	Fax Number	Phone Number
	Arthur J. Ulm, MD	615-902-3980	615-320-0007
	Robert A. Mericle, MD	615-902-3982	
	Robbi L. Franklin, MD	615-902-3983	
	Chine Sp. Logan, DO	615-320-3183	
	Ivan T. Stoev, MD	615-902-3981	
	Christopher M. Storey, MD	615-383-6329	

	Provider	Fax Number	Phone Number
	L. Brett Babat, MD	615-320-3186	615-986-1256
	Khan W. Li, MD	615-320-4178	
	William R. Schooley, MD	615-320-4106	
	Rex E. Arendall, MD	615-327-8975	
	Karl A. Sillay, MD	615-329-3044	

This request and authorization applies to:

- ALL healthcare information
- Healthcare information relating to the following treatment, condition, or dates:

- Other:

Patient Signature

Date Signed