Advanced Neurology
OF COLORADO

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Thank you for selecting our practice. In order to better serve your needs, please arrive 30 minutes prior to your appointment time and bring the following items with you:

- **COMPLETED** New Patient paperwork
- Insurance Card
- Driver's License or other form of photo identification
- Your co-payment if required by your insurance
- A copy of recent lab results and MRI/CT images and reports

PERSONAL INFORMATION:

First Name:_____ MI:_____Last Name:_____

Preferred Name: _____

Address:_____

City:_____State:_____Zip:_____

Date of Birth: _____/_____/_____ Sex: M / F Other_____Marital Status: _____

Home #: _(____)_____-_____Email Address:_____

Cell #: _(____)_____-_____Work #:_(____)_____-_____

EMERGENCY CONTACT:

Name:_____Relationship:_____Phone #:_(____)_____-_____

PHYSICIAN CARE TEAM:

Referring Physician:_____Phone #:_(____)_____-_____

Primary Physician:_____Phone #:_(____)_____-_____

INSURANCE AND GUARDIAN INFORMATION:

Primary Insurance:_____Policy holder name:_____

Patient's relationship to policy holder: Self / Spouse / Child / Other

Policy #:_____Group #:_____

Employer:_____SSN:_____DOB:_____

Secondary Insurance:_____Policy holder name:_____

Patient's relationship to policy holder: Self / Spouse / Child / Other

Policy #:_____Group #:_____

Patient Name _____
(Please Print)

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE

Please list the reason for your visit and describe your symptoms:

_____

_____

_____

_____

Have you had similar problems/symptoms in the past? Yes / No

How long has this condition existed? _____

ALLERGIES

Do you have any allergies to medications? Yes / No (**If Yes, list medication and reaction**)

_____

_____

_____

_____

TOBACCO HISTORY

Do you use tobacco? Circle all that apply: Cigarettes Cigars Chew

If yes, how many per day?_____how many years?_____ _____

Ever tried to quit? Yes / No Quit date: _____

MEDICAL HISTORY

Please list any medical conditions you have had in the past (include dates):

_____

_____

_____

_____

SURGICAL HISTORY

Please list any operations you have had in the past (include dates):

_____

_____

_____

_____

Patient Name _____
(Please Print)

FAMILY MEDICAL HISTORY

Do you have any family members that have ever had any of the following conditions?

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other:
Cancer									
Dementia									
Diabetes									
Fibromyalgia									
Hypertension									
Migraines									
Multiple Sclerosis									
Neuropathy									
Parkinsonism									
Psychiatric Problems									
Seizures									
Stroke									
Thyroid Disease									
Tremor									
Other:									
Other:									
Other:									

SOCIAL HISTORY

Do you consume alcoholic beverages? Yes / No

If yes, what type? _____

How many drinks per day, per week or per month?_____

Do you use recreational drugs? Yes / No

If yes, what type? Circle all that apply: Marijuana Methamphetamine Cocaine Other

How much per day, week or per month?_____

Patient Name _____
(Please Print)

What kind of work do you do? _____

How would you rate your current stress level? Low / Moderate / Severe

Is this the same or different from your usual stress level? Same / Different

Have you ever experienced an emotionally traumatic event in the past? Yes / No

Are you pregnant? Yes / No Are you breastfeeding? Yes / No

Are you planning on becoming pregnant in the near future? Yes / No

FALL SCREENING

Falls within last 3 months? Yes / No

Fear of falling? Yes / No

Difficulty ambulating? Yes / No

Do you use an assistive device? Circle all that apply: Cane Walker Wheel Chair Scooter

HEALTHCARE DIRECTIVE

Living Will? Yes / No Power of Attorney? Yes / No

PREVIOUS DIAGNOSTIC TESTS

If you have had any of the following tests, please write in the approximate date(s) they were performed and location of the test:

EEG (brain wave test):_____

MRI/MRA (list site, for example brain, neck, etc.):_____

CT/CTA head and/or neck: _____

Lumbar puncture (spinal tap):_____

EMG/NCS (nerve conduction study):_____

PHARMACY INFORMATION

Your preferred **LOCAL RETAIL** pharmacy (name & address):_____

_____

Your preferred **MAIL ORDER** pharmacy (name & address):_____

_____

Patient Name _____
(Please Print)

MEDICATIONS

Are you taking any medications at this time? Yes / No

Please list ALL medications including over the counter and supplements. If needed, please continue medications on the back of this sheet.

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Patient Name _____
(Please Print)

REVIEW OF SYSTEMS

Are you right or left hand dominant? Right / Left

Do you have any problems with the following? If yes, please circle all that apply:

Constitutional:
Fever
Chills
Weight Loss
Weight Gain

Eyes:
Blurred Vision
Double Vision
Eye Pain
Eye Redness

Gastrointestinal:
Nausea
Vomiting
Abdominal Pain
Blood in Stools

Musculoskeletal:
Muscle Pain
Neck Pain
Back Pain
Joint Pain

Skin:
Rash
Itching
Skin Wounds

Cardiovascular:
Chest Pain
Palpitations
Leg Swelling

Urinary:
Urgency
Frequency
Pain w/ Urination
Blood in Urine

Endocrine/Blood:
Bruise/Bleed Easily
Excessive Thirst
Deepening of Voice
Seasonal Allergies

Ears, Nose, Throat:
Hearing Loss
Tinnitus
Ear Pain
Congestion

Respiratory:
Cough
Shortness of Breath
Wheezing

Psychiatric/ Behavioral:
Depression
Suicidal Ideas
Nervous/Anxiety
Hallucinations
Personality Changes
Emotional Problems
Insomnia
Memory Loss

Neurological:
Dizziness
Tingling
Numbness
Tremor