

UPPER VALLEY NEUROLOGY NEUROSURGERY, PC

106 Hanover Street, Lebanon, NH 03766 Phone: 603.448.0447 Fax: 603.448.0019

Neurology

Donald W. Ayres, M.D.
Board Certified in Neurology
Added Qualification in Clinical Neurophysiology
ASN Certified in Neuroimaging – MRI & CT
Certified Physician Clinical Trial Investigator

Neurosurgery

Hulda B. Magnadottir, M.D.
President
Board Certified in Neurological Surgery
Harold J. Pikus, M.D.
Board Certified in Neurological Surgery

Joseph M. Phillips, M.D., Ph.D.
Board Certified in Neurological Surgery

Alyssa M. Pearl, PA-C
Board Certified by NCCPA

Administration

Kimberly McKinney Office Manager
Meredith Underhill, LPN Clinical Support Manager

Neurosurgery-Emeritus

Richard L. Saunders, M.D.
Board Certified in Neurological Surgery
Added Qualification in Cervical Spine

Rebecca M. Zebo, PA-C
Board Certified by NCCPA

Name _____

Address _____

City, State, Zip Code _____

Please complete all pages of this medical history form before reporting for your examination.

DOB: _____ **Age:** _____ **Sex:** M F **Handedness:** L R (circle)

Height: _____ **Current Weight:** _____

For what problem are you being referred to this office:

Do you believe that this problem is work related: Yes, No, If yes, explain:

Did this problem begin after an injury: Yes, No, If yes what kind of injury:

The problem is (circle): constant comes and goes improved worse

Medical history: Do you have any of the following medical conditions:

CONDITION	YES	NO	YEAR DIAGNOSED	WHAT TYPE
High blood pressure				
High cholesterol				
Depression				
Diabetes				
Asthma				
Ulcers				
Irregular heart rate				
Migraine headaches				
Seizures/Epilepsy				
Arthritis				
Lung disease				
Kidney disease				
Thyroid disease				
Skin disease				
Liver/Intestine disease				
Cancer				

Do you have Heart Disease? Yes or No What Type: _____
 Cardiologist: _____ Last Cardiology Appt: _____
 Other Conditions: _____

Have you ever had any of the following?

CONDITION	YES	NO	WHEN (YEAR)		
Heart Attack					
Heart Bypass Surgery					
Neck Injury					
Back Injury					
Stroke					
Head Injury				Did you black out?	Yes or No
Car Accident				Did you black out?	Yes or No

Please list all previous surgeries that you have had.

- 1) _____ When? _____ Where? _____
- 2) _____ When? _____ Where? _____
- 3) _____ When? _____ Where? _____
- 4) _____ When? _____ Where? _____
- 5) _____ When? _____ Where? _____
- 6) _____ When? _____ Where? _____

Social history:

Occupation: (if retired, list previous job) _____

Tobacco use: () Never smoked cigarettes/cigar
() Used to smoke _____ packs per day but quit in (year) _____
() Currently smoke _____ packs per day, started smoking at age _____

Do you use: Chewing Tobacco - Y/N E-Cigarette - Y/N Vaporizer - Y/N

Alcohol use: () Have never used alcohol () Drink occasionally () Drink daily
() Quit drinking in: _____
() I usually drink (circle) beer wine mixed drinks
And I usually have _____ drinks in one day.

Family history:

Are you adopted? Y/N

Mother: () Alive () Deceased Age ____ Cause of death if deceased: _____
Father: () Alive () Deceased Age ____ Cause of death if deceased: _____
Age of brothers: _____ If deceased, indicate age at time: _____
Age of sisters: _____ If deceased, indicate age at time: _____
Age of children: _____

Do/did any of these family members have any of the following medical conditions:

CONDITION	YES	NO	WHO (Mother, Father, Sister, Brother, Etc.)
High blood pressure			
Migraine Headaches			
Alzheimer's disease			
Multiple sclerosis			
Heart Attack			
Diabetes			
Seizures			
Tremors			
Stroke			
Carpal tunnel syndrome			

Other Conditions: _____

Who: _____

Medications

Allergies: Please list medications that you are allergic to:

Please list seasonal or environmental allergies:

Current Medications: Please list all your current medications and supplements with dosages and how you take them. (Option: Attach medication list from your pharmacy.)

Medication	Dosage	Taken	Why do you take it?
Example: Advil	200mg	2 tablets every 8 hours	Pain

Form Completed by: _____ Date: ___/___/___
Reviewed with patient by: _____ Date: ___/___/___

Review of Symptoms: For the following symptoms, please place a check mark “✓” next to those you currently experience and circle any that have been a problem in the past.

Constitutional

Fever
 Chills
 Headache

Feeling Poorly (Malaise)
 Feeling Tired (Fatigue)

Recent Weight Gain (___ lbs)
 Recent Weight Loss (___ lbs)

Eyes

Eye Pain
 Red Eyes

Eyesight Problems
 Discharge from Eyes

Dry Eyes
 Eyes Itch

ENT

Earache
 Loss of Hearing

Nosebleeds (Epistaxis)
 Nasal Discharge

Sore Throat
 Hoarseness

Cardiovascular

Chest Pain
 Palpitations

Heart Rate is Fast
 Heart Rate is Slow

Leg Claudication

Respiratory

Shortness of Breath
 Wheezing

Cough
 Labored Breath (Dyspnea on Exertion)

Short of Breath Lying Down (Orthopnea)
 Shortness of Breath that Awakens at Night (PND)

Gastrointestinal

Abdominal Pain
 Vomiting

Constipation
 Diarrhea

Heartburn
 Dark Stool (Melena)

Genitourinary

Painful Urination (Dysuria)
 Incontinence
 Hesitancy

Nighttime Urination (Nocturia)
 Testicular Pain
 Genital Lesion

Pelvic Pain
 Menstrual Cramps (Dysmenorrhea)
 Vaginal Discharge
 Abnormal Vaginal Bleeding

Musculoskeletal

Joint Pain (Arthralgia)
 Muscle Pain

Joint Swelling
 Joint Stiffness

Limb Pain
 Limb Swelling

Integumentary

Skin Lesions
 Skin Wound
 Dry Skin

Itching (Pruritus)
 Change in a Mole
 An Unusual Growth

Breast Pain
 Breast Lump

Neurological

Confused
 Convulsions

Dizziness
 Fainting (Syncope)

Limb Weakness (Paresis)
 Difficulty Walking

Psychiatric

Suicidal
 Sleep Disturbances

Anxiety
 Depression

Change in Personality
 Emotional Problems

Endocrine

Bulging Eyes (Proptosis)
 Hot Flashes

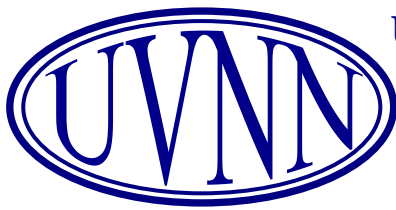
Muscle Weakness
 Erectile Dysfunction

Deepening of the Voice
 Feelings of Weakness

Hematologic/Lymphatic

Easy Bleeding
 Easy Bruising

Swollen Glands
 Swollen Glands in the Neck



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PATIENT INFORMATION

Patient name _____ Date of birth _____

Mailing address (If PO Box, please also provide Physical Address)

Home phone _____

Please circle the best number to reach you:
Home Work Cell

Work phone _____

Social Security # _____

Cell Phone _____

Marital Status _____

Race: (Please circle)

- White
- American/Alaskan Indian
- Black/African American
- Asian
- Native Hawaiian/Pacific Islander
- Other
- Declined

Ethnicity: (Please circle)

- Hispanic/Latino
- Non Hispanic/Latino
- Declined

Language:

or
Declined

Would you be interested in our patient portal?
 Yes No

Email Address: _____

Employer _____ Phone _____

Employer address _____

Primary care doctor _____ Phone _____

Referring doctor _____ Phone _____

Preferred Pharmacy _____ City/State _____

Person to notify in case of an emergency, their phone number and relation to you:

Do you have:

	Living Will	Yes	No
	Durable Power of Attorney for Healthcare	Yes	No

GUARANTOR INFORMATION

Who carries the insurance? _____ DOB: _____

SSN#: _____ Their relationship to you: _____

Employer and address which insurance is through

PLEASE HAVE RECEPTIONIST TAKE A COPY OF YOUR INSURANCE CARD.

****DOES YOUR INSURANCE REQUIRE A REFERRAL?***
If so, did you get one? Please let the receptionist know.

I authorize payment of medical benefits to Upper Valley Neurology Neurosurgery, PC for all services rendered. I understand I am financially responsible for any balances not fully paid by my insurance company.

I hereby authorize the release of my medical information related to these claims to my insurance company.

Signature _____ *Date* _____

If you are being seen due to an accident at work please complete the following:

ACCIDENT/WORKERS COMPENSATION INFORMATION

Date of accident: _____ **Claim #:** _____

Is this a workers compensation injury? (If yes, please indicate **place of employment** in which the accident occurred, their **address**, and **phone number**.)

Workers compensation/Liability insurance name, address and phone number:

Name:

Upper Valley Neurology Neurosurgery

DOB:

Shade in the area where you experience pain.

Brief Pain Inventory

Are you currently in pain? Yes No

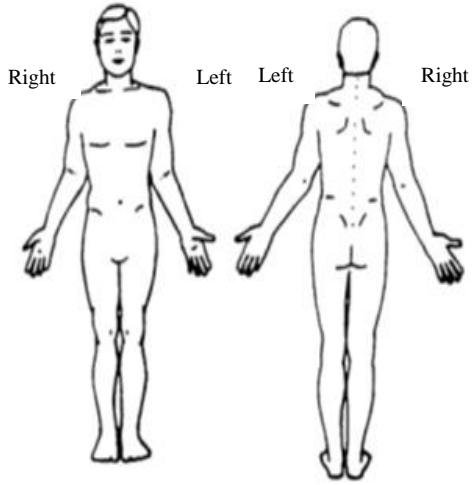
When did your pain begin?

What were you doing when the pain first occurred?

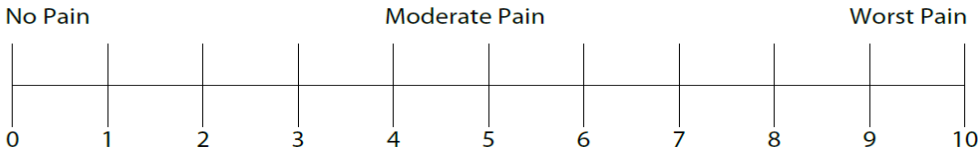
Has the pain improved or is it getting worse?

Using the diagram at the right, shade in the areas where you feel pain.

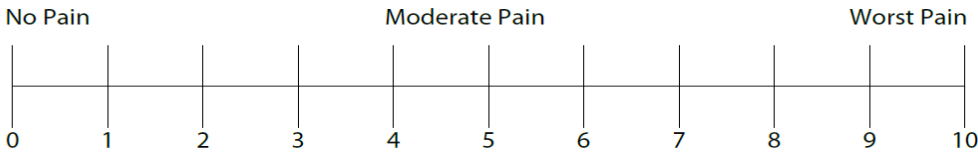
Put an "X" on the area (in the diagram) that hurts the most.



Please rate your pain by circling the one number below that best describes your pain on the average.



Please rate your pain by circling the one number below that describes your pain at its worst.



What activities or positions seem to make your pain worse (ex, walking, sitting, standing)?

What makes your pain better (ex, sitting, walking, lying)?

What treatments have been tried to improve your pain?

- | | |
|-----------------------------|-------------------|
| Physical Therapy | Pain medication |
| Chiropractic treatments | Muscle relaxants |
| Epidural steroid injections | Anti-Inflammatory |

What of the above treatments improved your pain or made in better?

What current medications are you taking for pain?