

Alpha Neurology PC

Patient Updated Personal Information Sheet

******* Please complete all areas and present your current insurance card (s), along with this completed form, to the receptionist when arriving at the office for your appointment.**

Name _____ DOB ____/____/____ SS _____

Address _____ City _____ State _____

Phone # _____ Work# _____ Cell # _____

Insurance Co. _____ ID# _____

Subscriber Name _____ DOB ____/____/____

Secondary Insurance _____ ID# _____

Subscriber Name _____ DOB ____/____/____

In an emergency, please contact _____

Relationship to patient _____ Tel # _____

Primary Physician _____ Tel # _____

*Please be sure to advise your physician at Alpha Neurology of any new allergies, surgeries or illnesses since your last visit to our office.

Patient Signature

Date

Alpha Neurology PC

Patient Name _____ Date of Birth _____ Date _____

Reason for Today's Visit _____

<p>Statistics: Height _____ Weight _____</p> <p>Current Medications: _____ _____ _____ _____ _____ _____ _____</p> <p>NEUROLOGICAL ___ Dizziness ___ Vertigo ___ Memory loss ___ Disorientation ___ Speech or language dysfunction ___ Inability to concentrate ___ Seizures ___ Taste, smell or touch disturbance ___ Headache ___ Migraine headache ___ Numbness or Tingling ___ General weakness ___ Muscle weakness ___ Slurred Speech ___ Blurred vision ___ Loss of consciousness ___ Balance problems ___ Falls ___ Depression ___ Fatigue ___ Neck pain ___ Back pain</p> <p>CONSTITUTIONAL ___ Fatigue (sluggish, tired) ___ Weight loss ___ Weight gain ___ Weight stable ___ Night Sweats ___ All negative</p>	<p>MUSCULOSKELETAL ___ Muscle cramping ___ twitching or pain ___ Joint swelling ___ Joint stiffness ___ Joint pain ___ Noise with joint movement ___ Arm or leg pain ___ All negative</p> <p>SKIN ___ Itching ___ Scars ___ Moles or lesions ___ Changes in color of moles or lesions ___ Rashes ___ All negative</p> <p>PSYCHIATRIC ___ Anxiety ___ sleep disturbance ___ Hallucinations ___ All negative</p> <p>CARDIOVASCULAR ___ Chest pain ___ Palpations ___ Heart Murmur ___ Irregular pulse ___ High blood pressure ___ Low blood pressure ___ Swelling ___ Coldness/numbness in fingers or toes ___ All negative</p> <p>EYES ___ Itching ___ Excessive tearing ___ Double vision ___ Light sensitivity ___ All negative</p> <p>RESPIRATORY ___ Difficulty breathing ___ Chronic cough ___ Asthma ___ Bronchitis ___ All negative</p>	<p>GENITOURINARY ___ Painful urination ___ Frequent Urination ___ Night urination ___ Unable to control urination ___ All negative</p> <p>ENDOCRINE ___ Diabetes ___ Adrenal problems ___ Changes in height or weight ___ Increased appetite ___ Increased thirst ___ Hair change/loss ___ All negative</p> <p>HEMATOLOGIC/LYMPHATIC ___ Anemia ___ Bleeding tendencies ___ Easy bruising ___ Fatigue ___ Recurrent infections ___ Slow healing from cuts ___ All negative</p> <p>ALLERGIC/IMMUNOLOGIC ___ Hay fever ___ Itching ___ Sneezing ___ Chronic clear nasal drainage ___ Conjunctivitis ___ Allergies to Medication ___ All negative</p> <p>ENMT ___ Sensitivity to noise ___ Ear Pain ___ Ringing in the ear ___ Nosebleeds ___ Sinusitis ___ Vertigo ___ Post nasal drip ___ Bleeding gums ___ Hoarseness ___ Difficulty Swallowing ___ All negative</p>
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Patient Signature

HealthCare Provider Signature

Alpha Neurology PC

Name _____ Date _____

PAST Medical History: Have you been diagnosed with any of the following?

- ☐ Heart Disease ☐ Parkinson's disease ☐ Neuropathy ☐ Lupus ☐ Obesity
☐ Coronary Artery Disease ☐ Multiple Sclerosis ☐ Stroke ☐ Gout ☐ COPD/Emphysema
☐ Diabetes Mellitus ☐ Pacemaker ☐ Rheumatoid Arthritis ☐ Carpal Tunnel ☐ High Cholesterol

Other _____

Previous Surgeries _____

Family History:

	Father	Mother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden, unexplained death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History:

Smoking: ☐ Yes, how many packs per day? _____ ☐ No, never ☐ Quit, when _____

Alcohol Use: ☐ Daily ☐ Socially

Recreational Drug use: ☐ Yes ☐ No

Employment: ☐ Employed ☐ Part Time ☐ Unemployed ☐ Retired

Marital Status: ☐ Single ☐ Married/Cohabiting ☐ Divorced/Separated ☐ Widowed

Have you, or a close family member or friend recently suffered any emotional stress: such as losing a job, a divorce, moving to a new location? If yes, please explain _____

If a Physician referred you to our office, please list his/her name or list a Physician's name you would like us to send a report to.

Dr's Name _____

Address _____

Patient Signature

Reviewing Physician's Signature