

Schenectady Neurological Consultants, P.C.

1401 Union Street
Schenectady, NY 12308
Phone (518) 381-9202
Fax (518) 381-1182

PATIENT'S PERSONAL DATA
(PLEASE PRINT)

Patient Name _____

Address _____

Street/Apartment _____

City _____ State _____ Zip _____

Telephone _____

Home _____ Work _____

Employer _____

Address _____

Street _____

City _____ State _____ Zip _____

Employer's Telephone _____

Next of Kin _____

Address _____

Street _____

City _____ State _____ Zip _____

Your Driver's License Number _____

Health Insurance in Effect? YES NO

Name of Insured _____ Date of Birth _____

Relationship to Insured _____

Primary Insurance Name _____

ID Number _____ Group Number _____

Secondary Insurance Name _____

ID Number _____ Group Number _____

Social Security Number _____

Date of Birth _____ Age _____ Sex Male Female Marital Status _____

Referring Physician _____

Primary Physician (If different from Referring Physician above) _____

Neurological Associates Physician You Are Seeing _____

Spouse's Employer _____

Address _____

Street _____

City _____ State _____ Zip _____

Spouse's Employer Telephone _____

Relationship To Next of Kin _____

Next of Kin's Telephone _____

Worker's Compensation or No Fault Accident?

Date of Injury _____ File Number _____

Employer _____

Insurance Carrier Worker's Comp No Fault

Address _____

Street _____

City _____ State _____ Zip _____

PAYMENT IS EXPECTED AT TIME OF VISIT

MEDICAL RELEASE OF INFORMATION

I Hereby authorize **SCHENECTADY NEUROLOGICAL CONSULTANTS, PC** to furnish medical information, including photocopies of my records, to insurance companies and to physicians. I also authorize release of medical information to the Motor Vehicle Bureau, when necessary to obtain or retain my driver's license.

I hereby assign **SCHENECTADY NEUROLOGICAL CONSULTANTS, PC**, where applicable, all payments for medical services, but not to exceed stated charges. A photographic copy of this authorization shall be as valid as the original. I certify that the information given above is complete and accurate to the best of my knowledge.

Signed: _____ Date: _____

Initial & Date for Subsequent Visits If no change: _____

SCHENECTADY NEUROLOGICAL CONSULTANTS, P.C.

Bruno P. Tolge, MD Sheldon B. Staunton, MD
Victor G. Bruce, PA-C Steven D. Hicks, PA-C
1401 Union Street
Schenectady, NY 12308
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HEALTH HISTORY

Please fill in the information below to the best of your ability

Name: _____ Age: _____ Date: _____
Height: _____ Weight: _____ Which hand do you write with: Right _____ Left _____
Primary Physician: _____ Referring Physician: _____
Additional Physicians: _____

Briefly, state the problem you have been referred for:

PAST MEDICAL HISTORY: (check any of the following that you are presently or in the past have been under treatment for)

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Chickenpox |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Kidney Disease/Failure | <input type="checkbox"/> Cancer or tumors (list type, area effected) |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Bladder Problems | _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Stroke (include Mini-strokes) | <input type="checkbox"/> Emphysema | _____ |

Other: (for females, include number of pregnancies and deliveries)

SURGERY: (list type of surgery and date/year)

| | |
|---------------------|-------------------|
| MEDICATIONS: | ALLERGIES: |
|---------------------|-------------------|

FAMILY: (indicate whether parents are alive or deceased, health problems or causes of death. For siblings - #alive/dead -names not required)

Mother: _____ Father: _____
Sisters: _____ Brothers: _____
Others: (Major or hereditary conditions in grandparents, aunts, uncles or cousins) _____

SOCIAL: Marital Status: _____ # in Household: _____ Occupation: _____
Tobacco: _____ Alcohol use: _____ Drugs: _____ Level of Education: _____

HPI: (for office use only)

PLEASE FILL IN OTHER SIDE

Review of Systems: Please indicate any personal history below:

| | | |
|--|---|---|
| <input type="checkbox"/> Constitutional Symptoms Good general health lately. No Yes Recent weight change. No Yes Fever. No Yes Fatigue. No Yes Headaches. No Yes | <input type="checkbox"/> Genitourinary Frequent urination. No Yes Burning or painful urination. No Yes Blood in urine. No Yes Change in force of stream when urinating. No Yes Incontinence or dribbling. No Yes Kidney stones. No Yes Sexual difficulty. No Yes Male- testicle pain. No Yes Female- pain with periods. No Yes Female- irregular periods. No Yes Female- vaginal discharge. No Yes Female- # of pregnancies. _____ Female- # of miscarriages. _____ Female- date of last pap smear... _____ | <input type="checkbox"/> Psychiatric Memory loss or confusion. No Yes Nervousness. No Yes Depression. No Yes Insomnia. No Yes |
| <input type="checkbox"/> Eyes Eye disease or injury. No Yes Wear glasses/contact lenses. No Yes Blurred or double vision. No Yes | <input type="checkbox"/> Musculoskeletal Joint pain. No Yes Joint stiffness or swelling. No Yes Weakness of muscles or joints. No Yes Muscle pain or cramps. No Yes Back pain. No Yes Cold extremities. No Yes Difficulty in walking. No Yes | <input type="checkbox"/> Endocrine Glandular or hormone problem.. No Yes Excessive thirst or urination. No Yes Heat or cold intolerance. No Yes Skin becoming drier. No Yes Change in hat or glove size. No Yes |
| <input type="checkbox"/> Ears/Nose/Mouth/Throat Hearing loss or ringing. No Yes Earaches or drainage. No Yes Chronic sinus problem or rhinitis.. No Yes Nose bleeds. No Yes Mouth sores. No Yes Bleeding gums. No Yes Bad breath or bad taste. No Yes Sore throat or voice change. No Yes Swollen glands in neck. No Yes | <input type="checkbox"/> Integumentary (skin, breast) Rash or itching. No Yes Change in skin color. No Yes Change in hair or nails. No Yes Varicose veins. No Yes Breast pain. No Yes Breast lump. No Yes Breast discharge. No Yes | <input type="checkbox"/> Hematologic/Lymphatic Slow to heal after cuts. No Yes Bleeding or bruising tendency... No Yes Anemia. No Yes Phlebitis. No Yes Past transfusion. No Yes Enlarged glands. No Yes |
| <input type="checkbox"/> Cardiovascular Heart trouble. No Yes Chest pain or angina pectoris. No Yes Palpitation. No Yes Shortness of breath with walking or lying flat. No Yes Swelling of feet, ankles or hands.. No Yes | <input type="checkbox"/> Neurological Frequent or recurring headaches.. No Yes Lightheaded or dizzy. No Yes Convulsions or seizures. No Yes Numbness or tingling sensations... No Yes Tremors. No Yes Paralysis. No Yes Head injury. No Yes | <input type="checkbox"/> Allergic/Immunologic History of skin reaction or other adverse reaction to: Penicillin or other antibiotics... No Yes Morphine, Demerol, or other narcotics. No Yes Novocain or other anesthetics.. No Yes Aspirin or other pain remedies No Yes Tetanus antitoxin or other serums. No Yes Iodine, Merthiolate or other antiseptic. No Yes Other drugs/medications: _____ _____ _____ Known food allergies: _____ _____ Environmental allergies: _____ _____ _____ |
| <input type="checkbox"/> Respiratory Chronic or frequent coughs. No Yes Spitting up blood. No Yes Shortness of breath. No Yes Wheezing. No Yes | | |
| <input type="checkbox"/> Gastrointestinal Loss of appetite. No Yes Change in bowel movements. No Yes Nausea or vomiting. No Yes Frequent diarrhea. No Yes Painful bowel movements or Constipation. No Yes Rectal bleeding or blood in stool Abdominal pain. No Yes | | |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Parent or Guardian _____
Date

Doctor's Review

Signature of Doctor

THE HEADACHE CENTER

Located at Upper Level – 1401 Union St.

Directors: Victor G. Bruce, PA-C Bruno P. Tolge, MD Steven D. Hicks, PA-C

SCHENECTADY NEUROLOGICAL CONSULTANTS, PC

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Headache Questionnaire

NAME: _____ DATE: _____

(Where requested place a number in the Large Box , Check in small Box)

- ① When did you start having headaches? (Age of year of onset) _____
- ② a) When did your headaches become a problem or concern? _____
b) Was there anything that occurred prior to this change in your headaches (i.e. severe illness, new medical condition, change in medication, head or neck injury, change in menstrual periods, etc) _____

- ③ a) How often do your headaches occur now? /day /week /month /year constant
b) How long have your headaches occurred at this rate? _____
c) Are your headaches worse better constant
- ④ How long does each headache last? hours days constant
- ⑤ a) On what part of your head/neck do your headaches start? _____
b) After the headache starts does it stay in the same place move around spread to all areas
- ⑥ How would you describe the pain? Throbbing/pulsating pressure stabbing/sharp dull other _____
- ⑦ Describe the intensity of the pain (1-3)
1. Mild: Does not inhibit work performance or other activities
2. Moderate: Inhibits but does not prevent activities
3. Severe: Unable to function with headache
- ⑧ Are any of the following symptoms associated with your headache?
Please mark (B) Before (✓) During (A) After
- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Loss of Vision – R L | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Odor Sensitivity | <input type="checkbox"/> Difficulty Understanding |
| <input type="checkbox"/> Visual Disturbance – R L | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Weakness to: Face - R L |
| <input type="checkbox"/> Blurring – R L | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Fainting | <input type="checkbox"/> Arm - R L |
| <input type="checkbox"/> Tearing – R L | <input type="checkbox"/> Neck Stiff/Tender | <input type="checkbox"/> Irritability | <input type="checkbox"/> Leg - R L |
| <input type="checkbox"/> Eyelid Droop – R L | <input type="checkbox"/> Pain with Chewing | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness to: Face - R L |
| <input type="checkbox"/> Eye Redness – R L | <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Arm - R L |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Noise Sensitivity | <input type="checkbox"/> Difficulty Talking | <input type="checkbox"/> Leg - R L |
- ⑨ Indicate any of the following that (✓) Trigger (bring on) OR (X) worsen your headache
- | | | | | | |
|---|--|--------------------------------------|--|--|--------------------------------------|
| <input type="checkbox"/> Too Little Sleep | <input type="checkbox"/> Bending | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Menstrual Periods | <input type="checkbox"/> Coughing/Sneezing | <input type="checkbox"/> Other Foods |
| <input type="checkbox"/> Too Much Sleep | <input type="checkbox"/> MSG | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Emotional Stress | <input type="checkbox"/> Social Activity | <input type="checkbox"/> Chocolate |
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Physical Activity | <input type="checkbox"/> Missed Meal | <input type="checkbox"/> Cheeses | <input type="checkbox"/> Contraceptives | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Weather Change | <input type="checkbox"/> Citrus Fruit | <input type="checkbox"/> Medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- ⑩ Do your headaches awaken you from sleep? _____

(please complete other side)

1 Which of the following improve your headache? Rest Sleep Darkness Quiet Hot or Cold compress
 Massage or Pressure to the scalp or temples

2 a) In the last **month** have your headaches caused you to miss: Leisure activities Work School
 How many Days

b) In the past **6 months** have your headaches caused you to miss: Leisure activities Work School

c) Has your productivity at work, school or home been affected by your headaches? Yes No

3 List all current medications you are taking (start with headache medicines and include aspirin, Tylenol, birth control pills, hormones, vitamins, cold & sinus pills, sleeping pills, etc.)

| NAME OF MEDICINE | DOSE IN MG PER PILL | HOW TAKEN (PILL, PATCH, SUPPOSITORY) | # TIMES TAKEN PER DAY | HOW LONG TAKEN (WKS OR MORE) | RELIEF * (0-3) | SIDE EFFECTS? |
|------------------|---------------------|--------------------------------------|-----------------------|------------------------------|----------------|---------------|
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* RELIEF CODE: 0 = NO RELIEF 1 = MILD RELIEF 2 = MODERATE RELIEF 3 = COMPLETE RELIEF

4 List previous headache medications you have taken (First daily preventative and then those used as needed for headache)

| NAME OF MEDICINE | DOSE IN MG PER PILL | HOW TAKEN (PILL, PATCH, SUPPOSITORY) | # TIMES TAKEN PER DAY | HOW LONG TAKEN (WKS OR MORE) | RELIEF * (0-3) | SIDE EFFECTS? |
|------------------|---------------------|--------------------------------------|-----------------------|------------------------------|----------------|---------------|
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* RELIEF CODE: 0 = NO RELIEF 1 = MILD RELIEF 2 = MODERATE RELIEF 3 = COMPLETE RELIEF

5 List previous treatments (other than medicine) and evaluations you have received in the past for your headaches.

6 Have any family members (Parents, brothers, sisters, grandparents, aunt/uncle, first cousin) had diagnosis or treatment for:

- Migraines Whom? _____
- Headache (other than migraines) Whom? _____
- Fibromyalgia Whom? _____
- Brain Tumors Whom? _____

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Please list all medications that you are **currently** taking, including over the counter medications, vitamins, minerals and supplements:

MEDICATION:

DOSAGE:

Please list all medications that you are **allergic** to below:

PATIENTS NAME: _____ DATE: _____

THE HEADACHE CENTER

Schenectady Neurological Consultants

Below you will find the instructions for filling out your headache calendar. Please try to be as complete as possible and bring this log with you to your appointment.

In the first section, find the box corresponding to **Time/Date** of your headache, then **grade the intensity** of the headache using the following scale:

- 1**= Mild (bothersome but does not inhibit work or other activities)
- 2**= Moderate (limits activities, impairs normal function)
- 3**= Severe (incapacitating, bed rest required)

Place the approximate number of hours the headache lasts below the intensity chart.

The second section allows you to **identify any symptoms** you experience in association to the headache:

B = Before ✓ = During **A**= After the headache

Female patients should place an **X** in the section to signify days for your menstrual period.

In the medication section; **write the name and dose** of any medicine taken for your headache (include off-the-shelf medications), and **place the number of pills taken** for each headache in the appropriate box. On the relief line under the medication used, **grade the effectiveness**. See example below:

1 = mild 2 = moderate 3 = severe (definitions on calendar)

| ↓ Time / Date ⇨ | 1 | 2 | 3 | |
|--|---|---|---|---|
| Morning | | | | <i>These #'s correspond to the date of the month Place intensity number during time of onset and continuation of headache</i> |
| Afternoon | | | | |
| Evening | | | | |
| Sleep time | | | | |
| HA duration (hours) ⇨ | | | | <i># of hours headache lasts</i> |
| Associated symptoms | | | | |
| B = before ✓ = during A= after | | | | |
| Light sensitivity | | | | <i>Any symptoms that are experienced before, during and / or after the headache can be recorded here</i> |
| Noise sensitivity | | | | |
| Nausea | | | | |
| Vomiting | | | | |
| Worse with movement | | | | |
| Blurred vision | | | | |
| Dizziness | | | | |
| Menstrual period | | | | <i>X – mark days of menses</i> |
| Medication & Relief | | | | |
| 0= none; 10 = minimal; 25 = 25%; 50 = moderate; 75 = 75%; 100 = complete | | | | |
| Relief ⇨ | | | | <i>Place name and dose or # of pills taken of any medication you might take when you get a headache and relief obtained</i> |
| | | | | |
| Relief ⇨ | | | | |

