

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 Richard J. Simmons, MD Lisa P. Abraham, MD
Victor G. Bruce, PA-C Steven D. Hicks, PA-C

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www.SchenectadyNeuro.com

HEALTH HISTORY

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

Name: _____ Age: _____ DOB: _____

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"/> Measles | <input type="checkbox"/> Asthma | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Seizures | <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Cancer or tumors (list type, area affected) _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease/Failure | _____ |

Other Medical Problems:

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

PREVIOUS HOSPITAL OR ER VISIT

MEDICATIONS:

ALLERGIES:

Please request any or all information to be sent to our office:

Blood Work MRI EEG CT Neuro Psychological Evaluation
MMR DPT Hepatitis Flu Chicken Pox HIB

Other _____
Other _____

PLEASE FILL IN OTHER SIDE

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms
Headaches No Yes
Fever No Yes
Developmental Delay. No Yes
Behavioral Problems. No Yes
School Problems No Yes

Genitourinary
Frequent urination. No Yes
Burning or painful urination. No Yes
Blood in urine. No Yes

Psychiatric
Confusion. No Yes
Nervousness. No Yes
Depression. No Yes
Insomnia. No Yes

Ears/Nose/Mouth/Throat
Hearing loss or ringing. No Yes
Earaches or drainage. No Yes
Nose bleeds. No Yes

Musculoskeletal
Joint pain. No Yes
Weakness of muscles or joints. No Yes
Difficulty in walking. No Yes

Endocrine
Glandular or hormone problem.. No Yes
Diabetes. No Yes

Cardiovascular
Heart trouble. No Yes
Palpitation. No Yes

Integumentary (skin)
Rash or itching. No Yes

Hematologic/Lymphatic
Slow to heal after cuts. No Yes
Bleeding or bruising tendency. No Yes
Anemia. No Yes

Respiratory
Chronic or frequent coughs. No Yes
Shortness of breath. No Yes
Wheezing. No Yes

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
Loss of consciousness No Yes

Allergic/Immunologic
History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics. No Yes
Novocain or other anesthetics.. No Yes
Tetanus antitoxin or other
Serums. No Yes
Other drugs/medications: _____
Known food allergies: _____
Environmental allergies: _____

Gastrointestinal
Change of appetite. No Yes
Nausea or vomiting. No Yes
Pain in bowel movements or constipation. No Yes
Frequent diarrhea No Yes

Eyes
Eye disease or injury. No Yes
Wear glasses/contact lenses. No Yes
Blurred or double vision. No Yes

Family Medical History (Seizures, developmental delay, miscarriage)

Who Lives in Home With The Patients?

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Developmental History (Check all that apply)

Birth Weight _____ Full Term Premature Vaginal Forceps Jaundice C-Section

Problems During Pregnancy, Labor, or Delivery: _____

Current Level of Schooling: _____

What specific question(s) do you have (if any) for the Doctor? _____

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 Patient or Guardian

Date

Signature of Doctor

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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: _____