NEUROSCIENCE SPECIALISTS

Robert L. Remondino, M.D., Eric S. Friedman, M.D., Robert E. Tibbs, Jr., M.D.,
Robert J. Wienecke, M.D., Benjamin T. White, M.D., Brian E. Snell, M.D., J. Bridger Cox, M.D.
14100 Parkway Commons Drive, Suite 100 • Oklahoma City, OK 73134
(405) 748-3300 • (800) 742-3136 • Fax (405) 749-1671
Email: nss@neurosurg.org • Website: www.neurosurg.org

Welcome to Neuroscience Specialists and thank you for choosing our practice as your neurosurgical provider! We look forward to supplying you the highest quality neurosurgical care in a professional and friendly manner. Before coming to your office appointment, please remember the following:

1. Complete the attached questionnaire and FAX or MAIL it back as soon as possible.

2. It is ESSENTIAL for you to bring your IMAGING CD'S. Your referring provider may send a copy of the radiology report. It is your responsibility to provide our office with the actual films or CD's. If they are not available, we may be forced to reschedule your appointment.

3. To bring your INSURANCE CARD(s) / DRIVER'S LICENSE.

4. To bring copies of your medical RECORDS.

If you have any questions, please feel free to contact our office. We look forward to meeting you.

Neuroscience Specialists, PC

Patient's Name:_____
First Middle Last

SS#: _____ Date of Birth:_____ Age:_____ Sex: ☐ M ☐ F

Email:_____

Patient's Address: _____

City:_____ State:_____ Zip:_____

Patient's Home #: _____ Work #: _____ Cell #: _____

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

Spouse Name:_____ Work #: _____ Cell #: _____

Emergency Contact (Other Than Your Spouse) Name:_____

Relation:_____ Phone #: _____

Ethnicity : ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to specify

Primary Language:_____ Race: _____

Level of Education: ☐ Post Graduate Degree ☐ College Degree ☐ Some College ☐ High School Grad ☐ Other

****If you were injured:** ☐ Auto Accident ☐ On the job ☐ Other_____
Date of Injury _____
If applicable, Attorney's Name: _____ Phone #:_____

Patient Work Status**:** Employer: _____Job Title: _____

☐ Retired from: _____

☐ Unemployed. Last employment and when: _____

☐ Long Term Disability, if so, what is disability: _____

☐ Work Comp, Employed by & time on the job prior to injury: _____

List all previous Work Comp injuries and dates: _____

Current work Status: ☐ Light Duty ☐ TTD ☐ No Longer Employed ☐ Full Duty

Who referred you to us: _____

Address_____ Ph. _____

Family Provider: _____

Address:_____Ph._____

This information is required for our office to file your Health Insurance

Not for WORKERS COMP

Primary Insurance Information:

Insurance Name: _____

ID Number: _____ Group Number: _____

Claims Address: _____

Relationship to Insured: _____

If insured is someone other than patient, Insured's Name: _____

Insured's date of birth: _____ Insured's SSN _____

Insured's Employer: _____

Secondary Insurance Information:

Insurance Name: _____

ID Number: _____ Group Number: _____

Claims Address: _____

Relationship to Insured: _____

If insured is someone other than patient, Insured's Name: _____

Insured's date of birth: _____ Insured's SSN _____

Insured's Employer: _____

Tertiary Insurance Information:

Insurance Name: _____

ID Number: _____ Group Number: _____

Claims Address: _____

Relationship to Insured: _____

If insured is someone other than patient, Insured's Name: _____

Insured's date of birth: _____ Insured's SSN _____

Insured's Employer: _____

Name_____

1. Date your symptoms began: _____

2. Please describe the type of medical problem or symptoms that you are being seen for today:

1._____ 2._____ 3._____ 4._____

3. If your symptoms were because of an accident or injury, please explain:_____

_____

4. Are your symptoms: ☐ Improving ☐ Resolved ☐ Unchanged ☐ Worsening

Current level of pain on the following scale:(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable) ☐

As best as you can, describe your symptoms in terms of: Location:

_____

Does the pain move or radiate anywhere:_____

Check any that apply, otherwise assumed as no.

Timing of symptoms	**Description of symptoms**	**Aggravators of symptoms**
☐ Constant	☐ Aches	☐ Coughing
☐ Occasional	☐ Throbs	☐ Sneezing
☐ Wake you up	☐ Burns	☐ Walking
☐ During activity	☐ Tingles	☐ Sleeping
	☐ Stabbing	☐ Bending or Stooping

5. If you're weak, describe where and the degree of weakness:_____ _____

What makes your condition worse?_____

What helps your condition?_____

Other body parts affected:_____

Have you had any treatment or surgeries for your current condition?

☐ Physical Therapy ☐ Epidural Steroids ☐ Chiropractic Care ☐ Traction ☐ Other:_____

Has there been any change in bowel or bladder function? ☐Yes ☐No

6. Do you now or have you ever had the following:

☐Heart disease ☐CAD – Coronary Artery Disease
☐Lung disorder ☐PVD – Peripheral Vascular Disease
☐Kidney disease ☐Anxiety
☐Mental disease ☐Multiple sclerosis
☐Clotting disorder ☐COPD – Chronic Obstructive Pulmonary Disease
☐Cancer
☐Arthritis
☐Osteoporosis

Other:_____

Name_____

7. Please list all surgeries you have had including the year they were performed:

☐ Appendectomy Date:_____
☐ Pacemaker Date:_____
☐ Carpal Tunnel Release Date:_____
☐ Hernia Repair Date:_____
☐ Hip Replacement Date:_____
☐ Hysterectomy Date:_____
☐ Tonsillectomy Date:_____
Discectomy ☐-Cervical ☐-Thoracic ☐-Lumbar Date:_____
Spinal Fusion ☐-Cervical ☐-Thoracic ☐-Lumbar Date:_____

Other surgeries: _____

8. Please list any medications that you are currently taking. List the name of the medicine, the dosage, frequency, and route:

Name	Dosage	Frequency	Route

9. List ANY allergies you may have, including METALS: ☐ **NO KNOWN ALLEGIES**

☐Aspirin	☐Hydrocodone	☐Morphine
☐Amoxicillin	☐Ibuprofen	☐**Nickel**
☐Bactrim	☐Iodine	☐Oxycodone
☐**Cobalt**	☐Ketalar	☐Penicillin
☐**Chromium**	☐Ketamine	☐Sulfa
☐Codeine	☐Latex	☐**Titanium**
☐Demerol	☐Meprobamate	☐Tramadol

OTHER:_____

Name_____

10. Social History

Tobacco use: ☐ Current ☐ Never ☐ Former ☐ Unknown

Type _____
Number of years _____
Packs per day _____
Tobacco per day _____
Ever tried to quit: ☐ Yes ☐ No
Year quit _____
Passive smoke exposure: ☐ Yes ☐ No

Alcohol Use: ☐ Yes ☐ No ☐ Formerly
Type _____
Frequency _____
Amount _____
Last Drink _____
Year Quit _____

Illegal Drugs: ☐ Yes ☐ No How much_____ Type_____

11. Has anyone in your immediate family had:

	Yes	**Mother**	**Father**	**Sister**	**Brother**
High Blood Pressure	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐

Name_____

Review of Systems

Are you currently experiencing any of the following symptoms? If yes please check the box next to the symptoms, all unmarked answers well be recorded as a no.

General

- ☐ Weakness
- ☐ Tiredness
- ☐ Lack of appetite
- ☐ Weight gain
- ☐ Chills
- ☐ Fever
- ☐ Night sweats
- ☐ Difficulty in sleeping

Genito Reproductive (Male)

- ☐ Sexually transmitted disease
- ☐ Decreased sexual drive
- ☐ Discharge from penis
- ☐ Testicular pain
- ☐ Lumps in testicles or scrotum
- ☐ Decrease in testicular size
- ☐ Difficulty achieving erection
- ☐ Taking male hormones

Genito Reproductive (Female)

- ☐ Sexually transmitted disease
- ☐ Decreased sexual drive
- ☐ Do you have menstrual irregularities
- ☐ Are you bothered by hot flashes
- ☐ Taking female hormones

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Abdominal Pain
- ☐ Bright red blood in stools
- ☐ Black stools

Endocrine

- ☐ Goiter
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Tremulousness of the hands
- ☐ Change in pitch of the voice
- ☐ Increased body hair
- ☐ Decreased body hair
- ☐ Increased thirst
- ☐ Increase in appetite

Urinary

- ☐ Incontinence of urine
- ☐ Pain or burning when urinating
- ☐ Frequent urination - day
- ☐ Frequent urination - night
- ☐ Urinary Tract Infection
- ☐ Extreme urge to urinate
- ☐ Difficulty starting urination
- ☐ Difficulty stopping stream
- ☐ Kidney stones

Cardiovascular

- ☐ Have you ever seen a heart specialist
- ☐ Chest pain, tightness or squeezing
- ☐ Heart attack
- ☐ Shortness of breath lying down
- ☐ Need to sit up to breathe
- ☐ Heart Racing
- ☐ Irregular heart beat (Palpitations)
- ☐ Heart murmur
- ☐ Swelling of the legs
- ☐ Varicose Veins
- ☐ Leg pain at rest
- ☐ Leg pain with exertion
- ☐ Blue/Purple hands or feet

Respiratory

- ☐ Cough
- ☐ Wheezing
- ☐ Asthma
- ☐ Shortness of breath at rest
- ☐ Shortness of breath with exertion
- ☐ Pain in the chest when you cough, sneeze or move
- ☐ Sleep apnea

Eyes, Ears, Nose, Throat

- ☐ Pain in the eyes
- ☐ Difficulty in hearing
- ☐ Ringing in your ears
- ☐ Discharge from the ears
- ☐ Nasal discharge (frequent)
- ☐ Hoarseness

Musculoskeletal

- ☐ Muscle pain
- ☐ Neck pain
- ☐ Shoulder or arm pain ☐Left ☐Right
- ☐ Back pain
- ☐ Pain down legs ☐Left ☐Right
- ☐ Painful joints
- ☐ Swelling of joints
- ☐ Redness of joints
- ☐ Stiffness of joints
- ☐ Deformities of the joints or extremities

Neurologic/Psychiatric

- ☐ Seizures
- ☐ Headaches
- ☐ Blackouts
- ☐ Dizziness
- ☐ Double vision
- ☐ Paralysis or weakness of limbs
- ☐ Loss of sensation
- ☐ Loss of balance
- ☐ Loss of coordination
- ☐ Difficulty in speaking
- ☐ Nervousness
- ☐ Depression
- ☐ Difficulties in going to sleep
- ☐ Early morning awakening
- ☐ Difficulty with memory of past events
- ☐ Difficulty with thinking
- ☐ Difficulty with problem solving
- ☐ Blurred vision
- ☐ Spots before eyes
- ☐ Stroke

Patient Signature_____ **Date**_____