

CENTER FOR NEUROLOGICAL DISORDERS, P.A.
1319 Summit Avenue, Suite 200
Fort Worth, TX 76102
(817) 336-0551 1-888-339-9629 FAX (817) 339-3940

NEUROSURGERY

GEORGE F. CRAVENS, M.D. F.A.C.S.
GREGORY A. WARD, M.D. F.A.C.S.
GREGORY H. SMITH, D.O. F.A.C.O.S.
PAUL H. CHO, M.D.

ANESTHESIA & PAIN MANAGEMENT

PETER LEONARD, M.D.

NEUROLOGY

THOMAS TRESE, D.O. F.A.C.N.

PATIENT REGISTRATION SHEET

Date: _____

Patient Name: Last _____ First _____ MI _____
Address _____ City _____ State _____ Zip Code _____
Date of Birth _____ Age _____ Social Security _____
Marital Status _____ Sex _____ Telephone () _____ Cell Phone _____
Employer _____ Telephone () _____
Occupation _____

Spouse or Parent's
Name: _____ DOB _____
Relation to Patient _____ Social Security _____
Spouse or Parent's Employer _____ Telephone () _____
Occupation _____

Referring Physician _____ M.D. / D.O.
Address _____ City _____ State _____ Zip _____

Family Physician _____ M.D./D.O.
Address _____ City _____ State _____ Zip _____

Who can we contact in case of emergency or if we need to change an appointment and cannot reach you?

Name _____ Relationship _____
Address _____ Phone () _____ Cell _____

INSURANCE INFORMATION

Primary Carrier Name _____
Group No. _____ Policy No. _____
Subscriber's Name _____ Relationship _____
Secondary Carrier Name _____
Group No. _____ Policy No. _____
Subscriber's Name _____ Relationship _____

Work related? Yes ___ No ___ Date of injury _____ Last Working Day _____

Employer's address _____ City _____ State _____ Zip _____

Workman's Comp Carrier Name _____ Telephone # _____

Address _____ Adjustor's Name _____ Claim # _____

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MEDICAL HISTORY

What are your main complaints? _____

What are your symptoms?

Were you injured in a motor vehicle accident ___yes ___ no Date of accident _____

Last working day _____

Did an injury cause or contribute to your symptoms/complaints? ___ yes ___ no

Head:

Unconscious _____

Headache: Where? _____

How Long? _____

How Frequent? _____

Vision of Hearing changes _____

Fainting or Dizziness _____

Worsening _____

Other _____

Back and Neck:

Back and Neck Pain _____

Leg/Arm Pain _____

Numbness or Tingling _____

Urinary Incontinence _____

Weakness _____

Improving _____

Other _____

PAST HISTORY:

1. List all allergies to food or drugs: _____

2. Surgeries: Type _____

3. Chronic diseases _____

4. Serious medical diseases requiring hospitalization (Dates)

5. All medications being taken now, including over the counter medications, dosage and who prescribed these? _____

6. Immunizations _____

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MEDICAL HISTORY

FAMILY HISTORY:

	Age	Living	Deceased	Health Problems
Mother	_____			
Father	_____			
Brother(s)	_____			
Sister(s)	_____			
Children	_____			

Circle any disease that runs in the family: Tuberculosis, Diabetes, Cancer, Heart Disease, Kidney disease, Mental Disease, Stroke

SOCIAL HISTORY:

Alcohol (How much; how often) _____
Caffeine (How much; how often) _____
Tobacco (How much daily) _____
Drug Use ___ yes ___ no

REVIEW OF SYSTEMS: (PAST AND PRESENT)

Circle if you have had:

HEENT: Failing Vision, Watering of eyes, Itching of eyes, Trouble with sinus, Frequent colds, Nose Bleeds, False teeth, Bleeding gums, or Hoarseness.

RESPIRATORY SYSTEM: Asthma, emphysema, bronchitis, COPD.

CARDIOVASCULAR SYSTEM: Angina, blocked arteries, palpitations, heart attack, high blood pressure, heart failure, irregular heartbeat.

GASTROINTESTINAL SYSTEM: Is your appetite good? ___ yes ___ no. Do you have or have you ever had an ulcer? ___ yes ___ no. Have you had a change in your bowel habits in the last few months? ___ yes ___ no. Do you have bloody stools? ___ yes ___ no. Have you ever had jaundice or hepatitis? ___ yes ___ no.

GENITOURINARY SYSTEM: Have you ever had blood in your urine? ___ yes ___ no. Have you been told that you have albumin in your urine in the past? ___ yes ___ no. Do you have trouble getting your stream of water started? ___ yes ___ no. Have you had surgery on your prostate gland? ___ yes ___ no. Have you had venereal disease? ___ yes ___ no. Do you have or

have you had impotency/sexual dysfunction ___ yes ___no. Do you have incontinence? ___yes ___no.

OBSTETRICAL HISTORY: How many pregnancies? ___ Miscarriages? ___ Abortions? ____, Full term deliveries ____. How many children? ____. Ages of children living and deceased _____. How many children adopted_____

BREASTS: History of breast cancer? ___yes ___no. Have you had discharge from your nipples? ___yes ___no. Soreness? ___yes ___no. Lumps? ___yes ___no. Biopsies? ___yes ___no.

MUSCULOSKELETAL: Rheumatoid arthritis? ___ yes ___no. Gout? ___yes ___ no

ENDOCRINE: Diabetes? ___yes ___no. Thyroid disease? ___yes ___ no.

PSYCHIATRIC Circle if you have had: Depression, schizophrenia, manic-depressive disorder, bipolar disorder, learning disorder.

Circle if you have ever had or now have:

HEMATOLOGICAL/ONC: History of cancer, anemia, sickle-cell disease, neoplasms, other_____

NEUROLOGICAL HISTORY:

Previous neck injury ___ no	If yes, when? _____
Previous back injury ___ no	If yes, when? _____
Previous head injury ___ no	If yes, when? _____
Stroke _____ no	If yes, when? _____
Hemorrhage _____ no	If yes, when? _____
Seizures _____ no	If yes, when? _____
Loss of consciousness ___ no	If yes, when? _____
Visual disturbances _____ no	If yes, when? _____

History reviewed with patient: _____

Signature of patient _____

Signature of Physician _____

Name _____ Date _____

PLEASE CIRCLE IF YOU ARE TAKING ANY OF THE FOLLOWING

ECHINACEA

GARLIC

GINGER

GINKO BILOBA

GINSENG

ST. JOHN'S WORT

METABOLIFE

OR ANYTHING SIMILAR, I.E., METABOLIFT, METABOLOSS, METABOLIZE

KAVA KAVA

FEVERFEW

EPHEDRA