

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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PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth _____

CHIEF COMPLAINT

Reason for today's visit: _____

Current problem is the result of a (n) _____ Check all that apply

___ Car Accident ___ Work Accident ___ Accident ___ Other

PAST HISTORY

Please list any prior major illnesses and/or injuries _____

<u>Surgeries/Hospitalizations</u>	<u>Year</u>	<u>Complications</u>
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Have you ever had problems with anesthesia? ___ YES ___ NO

<u>CURRENT MEDICATION (S)</u>	<u>DOSE</u>	<u>FREQUENCY</u>

ALLERGIES TO MEDICATIONS: _____

Patient Name: _____ Date of Birth _____

SOCIAL HISTORY

Occupation: _____

Marital Status: Single Married Divorced Widowed

Do you have children? yes no How many? _____

Do you live alone? yes no Who lives with you? _____

Do you smoke? Yes, I've smoked _____ packs of cigarettes per day for _____ years.
 Yes, I smoke cigars or a pipe.
 No, I have never smoked.
 No, I quit _____ years ago. At that time, I was smoking _____ packs per day for _____ years.

Do you drink alcohol? No, never (or rarely) No, but I used to
 Yes Daily 1 or more times a week 1 or more times a month

Are you at risk for AIDS (e.g., sexual orientation, drug abuse previous blood transfusion)?
 No Yes Please explain: _____

Review of Systems

Are you currently, or have you had, problems with:

Constitutional:

Fever	<input type="checkbox"/> yes	<input type="checkbox"/> no
Weight loss	<input type="checkbox"/> yes	<input type="checkbox"/> no
Excessive Fatigue	<input type="checkbox"/> yes	<input type="checkbox"/> no
Night sweats	<input type="checkbox"/> yes	<input type="checkbox"/> no

Eyes:

Wear glasses	<input type="checkbox"/> yes	<input type="checkbox"/> no
Infections	<input type="checkbox"/> yes	<input type="checkbox"/> no
Injuries	<input type="checkbox"/> yes	<input type="checkbox"/> no
Glaucoma	<input type="checkbox"/> yes	<input type="checkbox"/> no
Cataracts	<input type="checkbox"/> yes	<input type="checkbox"/> no

Ear, Nose, Throat and Mouth

Wear Hearing Aids – Date of last exam: _____	<input type="checkbox"/> yes	<input type="checkbox"/> no
Hearing loss	<input type="checkbox"/> yes	<input type="checkbox"/> no
Ear Pain	<input type="checkbox"/> yes	<input type="checkbox"/> no
Ear Infections	<input type="checkbox"/> yes	<input type="checkbox"/> no
Ringings in ears (Circle: Left Right Both)	<input type="checkbox"/> yes	<input type="checkbox"/> no
Balance Disturbance (e.g., Vertigo, Spinning)	<input type="checkbox"/> yes	<input type="checkbox"/> no
Nosebleeds	<input type="checkbox"/> yes	<input type="checkbox"/> no
Nasal Congestion	<input type="checkbox"/> yes	<input type="checkbox"/> no
Nasal Drainage – Amount _____ Color _____	<input type="checkbox"/> yes	<input type="checkbox"/> no
Inability to Smell	<input type="checkbox"/> yes	<input type="checkbox"/> no
Sinus Problems	<input type="checkbox"/> yes	<input type="checkbox"/> no
Sinus Headaches	<input type="checkbox"/> yes	<input type="checkbox"/> no
Sore Throats	<input type="checkbox"/> yes	<input type="checkbox"/> no
Mouth Sores	<input type="checkbox"/> yes	<input type="checkbox"/> no

Patient Name: _____ Date of Birth: _____

Cardiovascular:

Chest Pain or Angina 0 Date of last EKG _____	___ yes	___ no
High Blood Pressure	___ yes	___ no
Irregular Pulse	___ yes	___ no
Heart Murmur	___ yes	___ no
High Cholesterol	___ yes	___ no
Swelling in Feet or Hands	___ yes	___ no
Leg Pain While Walking	___ yes	___ no

Respiratory:

Asthma	___ yes	___ no
Chronic Cough	___ yes	___ no
Emphysema	___ yes	___ no
Shortness of Breath	___ yes	___ no
Bronchitis	___ yes	___ no
Pneumonia	___ yes	___ no
Lung Cancer	___ yes	___ no
Bloody Sputum	___ yes	___ no
Date of last Chest X-ray _____	___ yes	___ no

Gastrointestinal:

Indigestion or Pain with Eating	___ yes	___ no
Nausea	___ yes	___ no
Vomiting	___ yes	___ no
Blood in Your Vomit	___ yes	___ no
Liver Disease	___ yes	___ no
Jaundice	___ yes	___ no
Abdominal Pain	___ yes	___ no
Change in Your Bowel Habits	___ yes	___ no
Ulcers or Gastritis	___ yes	___ no
Colon Cancer	___ yes	___ no

Genitourinary:

Urinary Tract Infections	___ yes	___ no
Painful Urination	___ yes	___ no
Blood in Your Urine	___ yes	___ no
Difficulty Starting or Stopping Stream	___ yes	___ no
Incontinence	___ yes	___ no
Kidney Stones	___ yes	___ no

Genitourinary:

Prostate Cancer (males)	___ yes	___ no
Endometriosis (females)	___ yes	___ no
Uterine or Cervical Cancer (females)	___ yes	___ no

Musculoskeletal

Broken Bones – List _____	___ yes	___ no
Arm or Leg Weakness	___ yes	___ no
Back Pain	___ yes	___ no
Joint Pain or Swelling	___ yes	___ no
Arthritis	___ yes	___ no

Patient Name: _____ Date of Birth: _____

Integumentary:

Skin Disease yes no
Skin Cancer yes no
Breast Pain, Tenderness or Swelling (females) yes no
Nipple Discharge (females) yes no
Date and Result of last Mammogram (female) _____

Neurological:

Fainting Spells or "Blacking Out" yes no
Seizures yes no
Problems with Your Memory yes no
Disorientation yes no
Difficulty with Your Speech yes no
Inability to Concentrate yes no
Double or Blurred Vision yes no
Face Weakness yes no
Coordination in Arm and/or Legs yes no

Psychiatric:

Anxiety yes no
Depression yes no
Other Psychiatric Disorder
Treatment _____ yes no

Endocrine:

Diabetes yes no
Thyroid Disease yes no
Increased Appetite yes no
Excessive Thirst or Urination yes no
Hormone Problems yes no

Hematologic/Lymphatic:

Anemia yes no
Hemophilia yes no
Bleeding Tendencies yes no
Persistent Swollen Glands or Lymph Nodes yes no
Blood Transfusion yes no
If yes, when? _____

Allergic/Immunologic:

Food Allergies yes no
Inhalant (nasal) Allergies yes no
Immunologic Disorders yes no

The above information is accurate to the best of my knowledge:

Patient Signature

Date

I have reviewed the above information with the patient

Physician Name (Printed) and Signature

Date