

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.

LEE KESTERSON, M.D.

GREGORY A. WARD, M.D.

J. KEVIN KAUFMAN, M.D.

GREGORY H. SMITH, D.O., F.A.C.O.S.

ANESTHESIA & PAIN MANAGEMENT

PETER LEONARD, M.D.

PHYSICAL MEDICINE AND REHABILITATION

SANKAR PEMMARAJU, D.O.

NEUROLOGY

G.A. GUZMAN, M.D.

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

PSYCHOLOGY

ANDREW HOUTZ, Ph.D.

PATIENT REGISTRATION SHEET

Date _____

Patient Name _____
Last First MI

Address _____
Street Address City State Zip

Date of Birth _____ Age _____ Social Security# _____

Marital Status _____ Sex _____ Telephone (____) _____

Employer _____

Occupation _____ Business Phone (____) _____

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

Name _____ Relationship _____

Address _____ Phone (____) _____

Referring Physician _____ M.D./D.O.

Address _____

Were you injured on the Job? _____ Date of Injury/accident _____

Were you injured in a car wreck? _____ Date of wreck _____

Name of Attorney _____

Address _____ Phone (____) _____

INSURANCE INFORMATION:

Primary Insurance Name _____

Group# _____ Policy# _____

Subscriber's Name _____

Relationship _____

Secondary Insurance Name _____

Group# _____ Policy# _____

Subscriber's Name _____

Relationship _____

Workman's Comp Carrier Name _____

Group# _____ Policy# _____

Subscriber's Name _____

Relationship _____

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.

LEE KESTERSON, M.D.

GREGORY A. WARD, M.D.

J. KEVIN KAUFMAN, M.D.

GREGORY H. SMITH, D.O., F.A.C.O.S.

ANESTHESIA & PAIN MANAGEMENT

PETER LEONARD, M.D.

PHYSICAL MEDICINE AND REHABILITATION

SANKAR PEMMARAJU, D.O.

NEUROLOGY

G.A. GUZMAN, M.D.

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

PSYCHOLOGY

ANDREW HOUTZ, Ph.D.

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: _____

Surgeries/Hospitalizations	Year	Complications

Have you ever had problems with anesthesia? YES NO

Current Medication(s)	Dose	Frequency

PATIENT NAME: _____ DATE OF BIRTH: _____

ALLERGIES TO MEDICATION:

Family Member	Alive	Deceased	Age	Health status or cause of death
Granmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

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: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

REVIEW OF SYSTEMS

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

<i>CONSTITUTIONAL</i>	<i>Circle One</i>
Fever	YES NO
Weight Loss	YES NO
Excessive Fatigue	YES NO
Night Sweats	YES NO

<i>EYES</i>	<i>Circle One</i>
Wear Glasses	YES NO
Infections	YES NO
Injuries	YES NO
Glaucoma	YES NO
Cataracts	YES NO

<i>EAR, NOSE, THROAT AND MOUTH</i>	
Wear Hearing Aids – Date of Last Exam: _____	YES NO
Hearing Loss	YES NO
Ear Pain	YES NO
Ear Infections	YES NO
Ringing in Ears <i>Circle:</i> Left Right Both	YES NO
Balance Disturbance (e.g., Vertigo, Spinning)	YES NO
Nosebleeds	YES NO
Nasal Congestion	YES NO
Nasal Drainage – Amount _____ Color _____	YES NO
Inability to Smell	YES NO
Sinus Problems	YES NO
Sinus Headaches	YES NO
Sore Throats	YES NO
Mouth Sores	YES NO

<i>CARDIOVASCULAR</i>	
Chest Pain or Angina – 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

<i>RESPIRATORY</i>	
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

PATIENT NAME: _____

DATE OF BIRTH: _____

GASTROINTESTINAL

Circle One

- | | | |
|---------------------------------|-----|----|
| Indigestion of 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 you Urine | YES | NO |
| Difficulty Starting or Stopping Stream | YES | NO |
| Incontinence | YES | NO |
| Kidney Stones | YES | NO |
| 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 |
| Arm or Leg Pain | YES | NO |
| Joint Pain or Swelling | YES | NO |
| Arthritis | YES | NO |

INTEGUMENTARY

- | | | |
|---------------------------------------------|-----|----|
| Skin Disease | YES | NO |
| Skin Cancer | YES | NO |
| Breast Pain, Tenderness or Swelling (Males) | YES | NO |
| Nipple Discharge (Females) | YES | NO |
| Date and Result of Last Mammogram (Females) | YES | NO |

NEUROLOGICAL

- | | | |
|-----------------------------------|-----|----|
| Fainting Spells or “Blacking Out” | YES | NO |
| Seizures | YES | NO |
| Problems with Your Memory | YES | NO |
| Disorientation | YES | NO |

PATIENT NAME: _____

DATE OF BIRTH: _____

NEUROLOGICAL

Circle One

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
Hemophillia	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) & Signature

Date