



**ALICE PECK DAY  
MEMORIAL HOSPITAL**

**NEUROSURGERY SERVICES AT APD  
LOCATED AT UPPER VALLEY MEDICAL GROUP**

106 Hanover Street, Lebanon, NH 03766 Phone: 603.448.0447 Fax: 603.448.0019

**Joseph M. Phillips, M.D., Ph.D.**  
Board Certified in Neurological Surgery  
Board Certified in Pain Medicine

**Hulda B. Magnadottir, M.D.**  
Board Certified in Neurological Surgery

**Kristin J. Jamieson, PA-C**  
Board Certified by NCCPA

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**DATE** \_\_\_\_\_

**NAME** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**CITY, STATE, ZIP** \_\_\_\_\_

Please complete all pages of this medical history form before reporting for your examination.

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Married/ Single (circle) Handedness: L R (circle)

Height: \_\_\_\_\_ Normal Weight: \_\_\_\_\_

Family Dr. \_\_\_\_\_

Doctor who referred you to this office: \_\_\_\_\_

For what problem are you being referred to this office:

\_\_\_\_\_  
\_\_\_\_\_

When did this problem first begin: \_\_\_\_\_

Do you believe that this problem is work related: Yes, No, If yes, explain:

\_\_\_\_\_

Did this problem begin after an injury: Yes, No, If yes what kind of injury:

\_\_\_\_\_

What were you doing when the problem first started: \_\_\_\_\_

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What makes the problem better: \_\_\_\_\_

What makes the problem worse: \_\_\_\_\_

The problem is (circle) :    constant            comes and goes

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: Please list medications that you are allergic to: \_\_\_\_\_

\_\_\_\_\_

Please list seasonal or environmental allergies: \_\_\_\_\_

Current medications: Please list all your current medications with dosages:

- 1) \_\_\_\_\_ 5) \_\_\_\_\_  
2) \_\_\_\_\_ 6) \_\_\_\_\_  
3) \_\_\_\_\_ 7) \_\_\_\_\_  
4) \_\_\_\_\_ 8) \_\_\_\_\_

Past medical history: Do you have any of the following medical conditions:

High blood pressure:	Yes	No	Year diagnosed: _____	
High cholesterol:	Yes	No	Year diagnosed: _____	
Heart Disease:	Yes	No	Cardiologist: _____	What type: _____
			When was last Cardiology Appt: _____	
Diabetes:	Yes	No	Year diagnosed: _____	
Asthma:	Yes	No	Year diagnosed: _____	
Ulcers:	Yes	No	Year diagnosed: _____	
Irregular heart rate:	Yes	No	Year diagnosed: _____	
Migraine headaches:	Yes	No	Year diagnosed: _____	
Seizures/Epilepsy:	Yes	No	Year diagnosed: _____	
Arthritis:	Yes	No	Year diagnosed: _____	
Lung disease:	Yes	No	Year diagnosed: _____	What type: _____
Kidney disease:	Yes	No	Year diagnosed: _____	What type: _____
Thyroid disease:	Yes	No	Year diagnosed: _____	What type: _____
Skin disease:	Yes	No	Year diagnosed: _____	What type: _____
Liver/Intestinal disease:	Yes	No	Year diagnosed: _____	What type: _____
Cancer:	Yes	No	Year diagnosed: _____	What type: _____
Other:	_____			

Have you ever had any of the following:

Neck injury:            Yes    No    Year diagnosed: \_\_\_\_\_  
Back injury:            Yes    No    Year diagnosed: \_\_\_\_\_

Stroke: Yes No Year diagnosed: \_\_\_\_\_  
Heart bypass surgery: Yes No Year diagnosed: \_\_\_\_\_  
Head injury: Yes No Year it occurred: \_\_\_\_\_ Did you black out? Yes No  
Car accident: Yes No Year it occurred: \_\_\_\_\_ Did you black out? Yes No

Please list all previous hospitalizations and surgeries that you have had.

- 1) \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_
- 2) \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_
- 3) \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_
- 4) \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_
- 5) \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_
- 6) \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_

Social history:

Occupation: (if retired, list previous job) \_\_\_\_\_

Tobacco use: ( ) Never smoked  
( ) Used to smoke \_\_\_\_\_ packs per day but quit in (year) \_\_\_\_\_  
( ) Currently smoke \_\_\_\_\_ packs per day, started smoking at age \_\_\_\_\_

Alcohol use: ( ) Have never used alcohol ( ) Drink occasionally ( ) Drink daily  
( ) Quit drinking in: \_\_\_\_\_  
( ) I usually drink (circle) beer wine mixed drinks  
And I usually have \_\_\_\_\_ drinks in one day.

Family history:

Adopted: Y/N

Mother: ( ) Alive ( ) Deceased Age \_\_\_ Cause of death if deceased: \_\_\_\_\_

Father: ( ) Alive ( ) Deceased Age \_\_\_ Cause of death if deceased: \_\_\_\_\_

Age of brothers: \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ If deceased, indicate age at time: \_\_\_\_\_

Age of sisters: \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ If deceased, indicate age at time: \_\_\_\_\_

Age of children: \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do/did any of these family members have any of the following medical conditions:

High blood pressure: Y / N Who: \_\_\_\_\_

Migraine headaches: Y / N Who: \_\_\_\_\_

Alzheimer's disease: Y / N Who: \_\_\_\_\_

Multiple sclerosis: Y / N Who: \_\_\_\_\_

Heart attack: Y / N Who: \_\_\_\_\_

Diabetes: Y / N Who: \_\_\_\_\_

Seizures: Y / N Who: \_\_\_\_\_

Tremors: Y / N Who: \_\_\_\_\_

Stroke: Y / N Who: \_\_\_\_\_  
Carpal tunnel syndrome Y / N Who: \_\_\_\_\_  
Other: \_\_\_\_\_: Y / N Who: \_\_\_\_\_

Review of symptoms: Please circle any of the following symptoms that you currently experience:

General: Daytime tiredness, unintended weight gain/ loss, fevers, chills, skin rash, excessive thirst.

Eyes/ ENT: Blurred vision, double vision, hearing loss, nosebleeds.

Neuro: Headaches, sleep problems, swallowing problems, walking/balance problems.

Heart/ Lung: Shortness of breath, wheezing, chest pain, chronic cough.

GI: Abdominal pain, nausea, vomiting, diarrhea, constipation, dark stools.

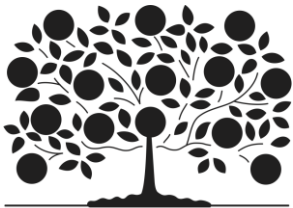
GU: Painful urination, change in urination frequency, recurrent urinary tract infections.

Musc/Skel: Joint pains, muscle pains, muscle twitching, muscle spasms.

Behavior: Depression, anxiety, tendency to cry, unable to enjoy daily activities.

Form completed by: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Reviewed with the patient by: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_



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## PATIENT INFORMATION

Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_

Mailing address \_\_\_\_\_

Home phone \_\_\_\_\_ Please circle the best number to reach you:  
Home Work Cell

Work phone \_\_\_\_\_ Social Security # \_\_\_\_\_

Cell Phone \_\_\_\_\_ Marital Status \_\_\_\_\_

Race: (Please circle)	Ethnicity: (Please circle)	Language:
White	Hispanic/Latino	_____
American/Alaskan Indian	Non-Hispanic/Latino	or
Black/African American	Declined	Declined
Asian		
Native Hawaiian/Pacific Islander		
Other		
Declined		

Email Address: \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Employer address \_\_\_\_\_

Primary care doctor \_\_\_\_\_ Phone \_\_\_\_\_

Referring doctor \_\_\_\_\_ Phone \_\_\_\_\_

Person to notify in case of an emergency and their phone number  
\_\_\_\_\_

Their relationship to you \_\_\_\_\_

**GUARANTOR INFORMATION**

Who carries the insurance? \_\_\_\_\_ DOB: \_\_\_\_\_

SSN#: \_\_\_\_\_ Their relationship to you: \_\_\_\_\_

Employer and address which insurance is through

\_\_\_\_\_

**\*PLEASE HAVE RECEPTIONIST TAKE A COPY OF YOUR INSURANCE CARD.\***

**\*\*DOES YOUR INSURANCE REQUIRE A REFERRAL?\***  
If so, did you get one? Please let the receptionist know.

I authorize payment of medical benefits to Upper Valley Neurology Neurosurgery, PC for all services rendered. I understand I am financially responsible for any balances not fully paid by my insurance company.

I hereby authorize the release of my medical information related to these claims to my insurance company.

*Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

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**If you are being seen due to an accident at work please complete the following:**

**ACCIDENT/WORKERS COMPENSATION INFORMATION**

**Date of accident:** \_\_\_\_\_ **Claim #:** \_\_\_\_\_

Is this a workers compensation injury? (If yes, please indicate **place of employment** in which the accident occurred, their **address**, and **phone number**.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Workers compensation/Liability insurance name, address and phone number:

\_\_\_\_\_

\_\_\_\_\_