

UPPER VALLEY NEUROLOGY NEUROSURGERY

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

Neurology

Donald W. Ayres, M.D.
President
Board Certified in Neurology
Added Qualification in Clinical Neurophysiology
ASN Certified in Neuroimaging – MRI & CT
Certified Physician Clinical Trial Investigator

Neurosurgery

Richard L. Saunders, M.D. (emeritus)
Board Certified in Neurological Surgery
Added Qualification in Cervical Spine
Joseph M. Phillips, M.D., Ph.D.
Board Certified in Neurological Surgery
Hulda B. Magnadottir, M.D.
Board Certified in Neurological Surgery
Kristin J. Jamieson, PA-C
Board Certified by NCCPA

Administration

Stephen G. Brown
Practice Administrator
Kimberly McKinney
Office Manager

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: _____

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: _____	
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.

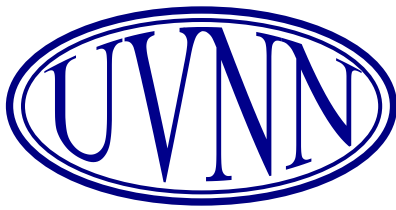
GU: Painful urination, change in urination frequency, recurrent urinary tract infections.

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 _____
Black/African American Declined or
Asian Declined Declined
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* _____

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:

