Oregon | Neurology Associates

PATIENT DOB: _____ / _____ / _____
MONTH DAY YEAR

PATIENT NAME: _____
LAST FIRST MI

Patient Medical History: Please mark all that apply

○ Abnormal Heartbeat	○ Chronic Headaches	○ Hepatitis C	○ Neuropathy	○ Sleep Apnea
○ Alcoholism	○ Colon Cancer	○ High Blood Pressure	○ Osteoporosis	○ Stomach Cancer
○ Anemia	○ COPD	○ High Cholesterol	○ Ovarian Cancer	○ Stroke
○ Anxiety/Panic Attacks	○ Dementia	○ HIV/AIDS	○ Pancreatic Cancer	○ Thyroid Disease
○ Arthritis	○ Depression	○ IBS	○ Parkinson Disease	○ TIA
○ Asthma	○ Diabetes, Childhood	○ Kidney Cancer	○ Passing Out/ Fainting	○ Tremor
○ Atrial Fibrillation	○ Diabetes, Adult Onset	○ Liver Cancer	○ Peptic Ulcer Disease	○ Tuberculosis
○ B12 Deficiency	○ Esophageal Cancer	○ Liver Disease	○ Pituitary Tumor	○ Uterine Cancer
○ Bladder Cancer	○ Fibromyalgia	○ Lung Cancer	○ Prostate Cancer	○ Vertigo
○ Bleeding Disorder	○ Glaucoma	○ Lymphoma	○ Rectal Cancer	○ None
○ Blood Clots	○ Head/Neck Cancer	○ Macular Degeneration	○ Skin Cancer	
○ Brain Cancer	○ Heart Disease	○ Melanoma	○ Seizures/Epilepsy	
○ Breast Cancer	○ Heartburn	○ Mental Illness	○ Severe Anesthesia Complications	
○ Cervical Cancer	○ Hepatitis A	○ Multiple Sclerosis	○ Sexually Transmitted Diseases	
○ Chronic Back/ Neck Pain	○ Hepatitis B	○ Neurological Disease	○ Shingles	
○ Other:				

Patient Surgical History: Please mark all that apply

○ Heart Bypass	○ Orthopedic (Bone)
○ Pacemaker/Defibrillator	○ Joint Replacement
○ Heart Stent	○ Hysterectomy
○ Heart Valve Replacement	○ Gallbladder
○ Brain Aneurysm	○ Cataract Removal
○ Carotid Artery	○ Weight Loss Surgery
○ Leg Artery	○ Carpal Tunnel Release
○ Brain Tumor	○ Lumbar Spine
○ Other Cancer	○ Cervical Spine
○ Transplant	○ None
○ Other:	

Prior Neurodiagnostic Testing: Please mark all that apply

MRI

- ○ Head
- ○ Neck
- ○ Lumbar
- ○ Other:

Date(s):

_____

Testing Facility:

- ○ Oregon Imaging Center
- ○ Willamette Valley Imaging
- ○ Other:

CT

- ○ Head
- ○ Neck
- ○ Lumbar
- ○ Other:

Date(s):

_____

Testing Facility:

- ○ Sacred Heart Hospital
- ○ McKenzie-Willamette Hospital
- ○ Other:

NCV/EMG

Date(s):

_____

Testing Facility:

_____

EEG

Date(s):

_____

Testing Facility:

- ○ Sacred Heart Hospital
- ○ McKenzie-Willamette Hospital
- ○ Other:

Family History

- ○ Family History is unknown (if yes, skip to **Social History**)
- ○ Family History is unremarkable

Coronary Heart Disease (CHD): please check all that apply

- ○ No Family History of CHD

Yes, Family History of CHD in:

- ○ Father, younger than 55
- ○ Brother, younger than 55
- ○ Son, younger than 55
- ○ Mother, younger than 65
- ○ Sister, younger than 65
- ○ Daughter, younger than 65

Family History

Please mark all that apply:

	Father	Mother	Sibling	Grandparent
Abnormal Heartbeat	○	○	○	○
Alcoholism	○	○	○	○
Atrial Fibrillation	○	○	○	○
B12 Deficiency	○	○	○	○
Blood Clots	○	○	○	○
Brain Cancer	○	○	○	○
Breast Cancer	○	○	○	○
Chronic Headaches	○	○	○	○
Colon Cancer	○	○	○	○
Dementia	○	○	○	○
Depression	○	○	○	○
Diabetes	○	○	○	○
Heart Disease	○	○	○	○
High Blood Pressure	○	○	○	○
High Cholesterol	○	○	○	○
Lung Cancer	○	○	○	○
Lymphoma	○	○	○	○
Melanoma	○	○	○	○
Mental Illness	○	○	○	○
Multiple Sclerosis	○	○	○	○
Neurological Disease	○	○	○	○
Neuropathy	○	○	○	○
Parkinson Disease	○	○	○	○
Passing Out/Fainting	○	○	○	○
Pituitary Tumor	○	○	○	○
Prostate Cancer	○	○	○	○
Seizures/Epilepsy	○	○	○	○
Stroke	○	○	○	○
Thyroid Disease	○	○	○	○
TIA	○	○	○	○
Tremor	○	○	○	○

Social History

Women Only:

Do you use birth control? (circle one) YES NO

Are you pregnant? (circle one) YES NO

Are you considering becoming pregnant? (circle one) YES NO

Social History

Do you have children? (circle one) YES NO

Status of Mother: (circle one) ALIVE DECEASED UNKNOWN

If deceased, died of: _____ Age at death: _____

Status of Father: (circle one) ALIVE DECEASED UNKNOWN

If deceased, died of: _____ Age at death: _____

Tobacco Use:
(circle one) Never Former Current

If current or former tobacco user: (circle one) Cigarettes Smokeless Tobacco

Year Started: _____ Current Packs/Day: _____ Year Quit: _____ Previous Packs/Day: _____

Alcohol Use:
How often have you had a drink containing alcohol in the past year? (select one)

○ Never ○ Monthly or Less ○ 2-4 times a month ○ 2 or 3 times a week ○ +4 times a week

How many drinks do you have on a typical day when you were drinking in the past year? (select one)
○ 1 or 2 ○ 3 or 4 ○ 5 or 6 ○ 7 to 9 ○ + 10

How often did you have 6 or more drinks on one occasion during the past year? (select one)

○ Never ○ Less than monthly ○ Monthly ○ Weekly ○ Daily ○ Almost Daily

Drug Use:
(circle one) Never Previous Current

If current or previous, which ones? (mark all that apply)

○ Heroin ○ Methamphetamine ○ Cocaine
○ Marijuana ○ Illicit Prescriptions ○ Other: _____

Caffeine Use, daily: (select one) ○ 0-1 cups ○ 2-3 cups ○ 4-5 cups ○ + 6 cups

Marital Status: (select one)
○ Married ○ Single ○ Divorced ○ Widowed ○ Domestic Partner

Employment Status: (select one)
○ Part-Time ○ Full-Time ○ Homemaker ○ Unemployed ○ Disabled ○ Retired

Social History

Education Level: (select one)

- ○ 8th grade or less
- ○ High School
- ○ Some college
- ○ Two year degree
- ○ Four year degree
- ○ Graduate School

Patient's Dominant Hand: (select one)

- ○ Left
- ○ Right

Medications

Please list all prescription and over-the-counter medications you are taking at this time

Name of Medication	Dosage/Strength	# Per Day

Allergies

Please list all allergies (including environmental, medication, and food)

Demographic Information:

Preferred Language ○ English ○ Spanish ○ Other:

Ethnicity ○ Hispanic or Latino ○ NOT Hispanic or Latino ○ Declined ○ Other:

Race ○ American Indian ○ Asian ○ Black or African American ○ Other:
○ Native Hawaiian ○ White ○ Declined

SPRINGFIELD OFFICE:
1 Hayden Bridge Way, Springfield, OR 97477

FLORENCE OFFICE:
340 9th Street, Florence, OR 97439

Oregon | Neurology Associates

Patient Registration

PATIENT INFORMATION

Name: _____
Preferred Name: _____
Date of Birth: _____ **Sex:** [ ]M [ ]F
Social Security #: _____
Address: _____
_____
City,State,Zip: , _____
Primary Phone: _____ [ ]Home [ ]Cell [ ]Work
Secondary Phone: _____ [ ]Home [ ]Cell [ ]Work
Tertiary Phone: _____ [ ]Home [ ]Cell [ ]Work

Referring Physican: _____
Primary Physician: _____
Employment Status: [ ]Employed [ ]Retired [ ]Unemployed
Employer: _____
Employer Phone: _____
Email:
Marital Status: [ ]Married [ ]Single [ ]Divorced

SPOUSE OR PARENT INFO

Spouse or Parent: _____
Date of Birth: _____
Social Security #: _____
Address: _____
_____

Employer: _____
Work Phone: _____

INSURANCE INFORMATION

If you would like us to bill your insurance, please bring a copy of your insurance card with you to your appointment.

Primary Insurance Company: _____
Policy/Group Number: _____ **Subscriber ID:** _____
Name of Subscriber: _____ **Date of Birth:** _____

Secondary Insurance Company: _____
Policy/Group Number: _____ **Subscriber ID:** _____
Name of Subscriber: _____ **Date of Birth:** _____

If applicable, check which applies: ☐ Work Injury (see below) ☐ Auto Injury (Date:_____) ☐ Accident (Date:_____)

WORK INJURY

Date of Injury: _____ **Claim Number:** _____
Employer at date of injury: _____
On-the-job Insurance Company: _____
_____