Oregon | Neurology

PATIENT DOB: _____ / _____ / _____
MONTH DAY YEAR

PATIENT NAME: _____
LAST FIRST MI

Patient Medical History: Please mark all that apply

○ Abnormal Heartbeat	○ ADD/ADHD	○ Anemia	○ Problems with Anesthesia
○ Anxiety/Panic Attacks	○ Asthma	○ Autism/Asperger's	○ Autoimmune Disorders
○ Bedwetting	○ Bipolar Disorder	○ Birth Defects	○ Bleeding Disorder
○ Blindness	○ Blood Clots	○ Cancer	○ Cerebral Palsy
○ Constipation/Encopresis	○ Cystic Fibrosis	○ Deafness	○ Depression
○ Diabetes	○ Eczema	○ Epilepsy/Seizure	○ Fainting/Blackout
○ Glaucoma	○ Genetic Disorders	○ Headache	○ Hepatitis
○ Heart Attack	○ Heart Defect	○ High Blood Pressure	○ High Cholesterol
○ HIV/AIDS	○ IBS	○ Kidney/Urinary Tract Disorders	○ Learning Disability
○ Intellectual Disability	○ Muscle Disease	○ Neuropathy	○ Nystagmus
○ OCD	○ Rheumatic Fever	○ Schizophrenia	○ SIDS/Crib Death
○ Sleep Apnea	○ Stomach/Digestion Disorders	○ Sexually Transmitted Diseases	○ Strabismus
○ Tuberculosis	○ Thyroid Disease	○ Tic/Tourette Syndrome	○ Tremor
○ Other:			

Patient Surgical History: Please mark all that apply

○ Carotid Endarterectomy	○ Ileac/Femoral Bypass	○ Brain Aneurysm
○ Craniotomy	○ Carpal Tunnel	○ Cataract
○ Cervical Spine	○ Cholecystectomy	○ CABG
○ Heart Valve	○ Hysterectomy	○ Join Replacement
○ Lumbar Spine	○ Orthopedic	○ Pacemaker/Defibrillator
○ Coronary Stent	○ Transplant	○ Weight Loss
	○ 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:

Patient Birth History

Where was the child born?

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

Birth Weight: _____ lbs. _____ oz.

Apgar Score: (please circle)

1 min:	0	1	2	3	4	5	6	7	8	9	10
5 min:	0	1	2	3	4	5	6	7	8	9	10

Problems During pregnancy with this child:

- ○ Diabetes
- ○ Fetal Distress
- ○ Premature labor
- ○ Bleeding
- ○ Hypertension
- ○ Other: _____
- ○ None

Problems during delivery of this child:

- ○ C-Section
- ○ Abnormal fetal heart rate
- ○ Vacuum extraction
- ○ Meconium staining
- ○ Premature rupture of membranes
- ○ Other: _____
- ○ None

Developmental History

Did child develop at same age as siblings? (circle one) YES NO

At what age did the patient:

	Lift head?	Roll over?	Sit without support?	Begin walking?	Say their first word?	Make their first sentence?	Pedal a tricycle?	Become toilet-trained?
3 Months	○	○	○	○	○	○	○	○
4 Months	○	○	○	○	○	○	○	○
5 Months	○	○	○	○	○	○	○	○
6 Months	○	○	○	○	○	○	○	○
7 Months	○	○	○	○	○	○	○	○
8 Months	○	○	○	○	○	○	○	○
9 Months	○	○	○	○	○	○	○	○
10 Months	○	○	○	○	○	○	○	○
11 Months	○	○	○	○	○	○	○	○
12 Months	○	○	○	○	○	○	○	○
13 Months	○	○	○	○	○	○	○	○
14 Months	○	○	○	○	○	○	○	○
15 Months	○	○	○	○	○	○	○	○
16 Months	○	○	○	○	○	○	○	○
17 Months	○	○	○	○	○	○	○	○
18 Months	○	○	○	○	○	○	○	○
19 Months	○	○	○	○	○	○	○	○
20 Months	○	○	○	○	○	○	○	○
21 Months	○	○	○	○	○	○	○	○
22 Months	○	○	○	○	○	○	○	○
23 Months	○	○	○	○	○	○	○	○
2 Years	○	○	○	○	○	○	○	○
3 Years	○	○	○	○	○	○	○	○
4 Years	○	○	○	○	○	○	○	○
5 Years	○	○	○	○	○	○	○	○
Unknown	○	○	○	○	○	○	○	○

Social History

Family changes since symptoms began: (mark all that apply)

○ A new child ○ A marriage ○ A divorce ○ None

○ A job change ○ Serious illness ○ A death

School Name: _____ Grade Level: _____

Average Grades: (circle one) A's B's C's D's C's F's

Repeated a grade? (circle one) YES NO

Social History

School days missed due to illness: (circle one) 0 1-5 6-10 10-20 > 20

How does child get along with others? (circle one) Not well As expected Very well

Discipline or behavior problems in school? (circle one) YES NO

Participates in sports: (circle one) YES NO

Child on IEP: (circle one) YES NO *If yes, for what*? _____

Drug use: (circle one) YES NO

If yes, for how many years? ○ Less than 1 ○ 1-2 ○ 3-4 ○ 5-6 ○ +7

Is there a history of physical and/or sexual abuse to the patient? (circle one) YES NO

Is the child adopted? (circle one) YES NO

Who has legal custody? (circle one)

Both parents Mom Dad Grandparents Court Other:

Patient writes with this hand: (circle one) RIGHT LEFT

Gynecological History: Women only

Has patient begun menstruating? (circle one) YES NO

Age at menarche: _____

LMP: _____ /_____ /_____

Is patient on birth control? (circle one) YES NO

Has patient ever been pregnant? (circle one) YES NO

Family History: (please mark all that apply)

	Father	Mother	Sibling	Grandparent	Other	If other, please specify:
Abnormal Heartbeat	○	○	○	○	○	
ADD/ADHD	○	○	○	○	○	
Problems with Anesthesia	○	○	○	○	○	
Anxiety/Panic Attacks	○	○	○	○	○	
Autism/Asperger's	○	○	○	○	○	
Autoimmune Disorders	○	○	○	○	○	
Bipolar Disorder	○	○	○	○	○	
Birth Defects	○	○	○	○	○	
Bleeding Disorder	○	○	○	○	○	

Family History: (please mark all that apply)

	Father	Mother	Sibling	Grandparent	Other	If other, please specify:
Blindness	○	○	○	○	○	
Blood Clots	○	○	○	○	○	
Cancer	○	○	○	○	○	
Cerebral Palsy	○	○	○	○	○	
Deafness	○	○	○	○	○	
Depression	○	○	○	○	○	
Diabetes	○	○	○	○	○	
Epilepsy/Seizure	○	○	○	○	○	
Fainting/Blackout	○	○	○	○	○	
Glaucoma	○	○	○	○	○	
Genetic Disorders	○	○	○	○	○	
Headache	○	○	○	○	○	
Heart Attack	○	○	○	○	○	
Heart Defect	○	○	○	○	○	
High Blood Pressure	○	○	○	○	○	
High Cholesterol	○	○	○	○	○	
Learning Disability	○	○	○	○	○	
Mental Retardation	○	○	○	○	○	
Muscle Disease	○	○	○	○	○	
Neuropathy	○	○	○	○	○	
Nystagmus	○	○	○	○	○	
OCD	○	○	○	○	○	
Rheumatic Fever	○	○	○	○	○	
Schizophrenia	○	○	○	○	○	
SIDS/Crib Death	○	○	○	○	○	
Strabismus	○	○	○	○	○	
Thyroid Disease	○	○	○	○	○	
Tic/Tourette Syndrome	○	○	○	○	○	
Tremor	○	○	○	○	○	

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

Oregon | Neurology

Patient Profile

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

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

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: _____
_____

12/16/2022