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DUTCHESS NEUROLOGY

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Diplomate American Board of Psychiatry and Neurology in Neurology
Diplomate American Board of EEG and Neurophysiology
Board Certified Medical Management
Diplomate American Board of Sleep Medicine
Diplomate American Board of Disability Analysts

WELCOME TO OUR OFFICE

THANK YOU FOR CHOOSING OUR OFFICE. IN ORDER TO SERVE YOU PROPERLY, WE WILL NEED THE FOLLOWING INFORMATION. ***(PLEASE PRINT)***
ALL INFORMATION WILL REMAIN CONFIDENTIAL.

TODAY'S DATE _____ HAVE YOU BEEN SEEN BY US BEFORE? [ ]yes [ ]no

PATIENT'S NAME _____ SEX _____ DATE OF BIRTH _____

MARITAL STATUS [ ]single [ ]married [ ]divorced [ ]widowed SOCIAL SECURITY NUMBER _____

ADDRESS _____

IF CHILD, PARENT OR GUARDIAN NAME _____ DATE OF BIRTH OF INSURED _____

HOME PHONE _____ WORK PHONE _____ OCCUPATION _____

NAME OF EMPLOYER _____ EMPLOYER'S ADDRESS _____

DO YOU HAVE MEDICAL INSURANCE? [ ]yes [ ]no IF YES, POLICY NUMBER _____

NAME AND ADDRESS OF INSURANCE COMPANY _____

INSURANCE PHONE # _____ IS YOUR INSURANCE A GROUP PLAN THROUGH YOUR EMPLOYER? [ ]yes [ ]no

SUBSCRIBER NAME _____ GROUP NAME AND NUMBER _____

NAME AND ADDRESS OF SECONDARY INSURANCE, IF ANY _____

POLICY NUMBER _____ SUBSCRIBER NAME _____

ARE YOU BEING SEEN FOR A WORK RELATED INJURY? [ ]yes [ ]no

ARE YOU BEING SEEN FOR A NO-FAULT (AUTO) INJURY? [ ]yes [ ]no

DATE OF INJURY _____ NAME OF INSURANCE CARRIER _____

ADDRESS OF INSURANCE CARRIER _____

CARRIER CASE OR FILE NUMBER _____ WCB NUMBER _____

ATTORNEY'S NAME AND ADDRESS _____

SPOUSE'S NAME AND SOCIAL SECURITY NUMBER _____

NAME AND PHONE NUMBER OF NEAREST FRIEND / RELATIVE NOT LIVING WITH YOU _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PRIMARY CARE PHYSICIAN _____

WHAT IS YOU CHIEF COMPLAINT? _____

I HEREBY AUTHORIZE THE PROVIDER TO FILE SUCH CLAIM IN MY BEHALF SO THAT THE PROVIDER MAY REALIZE PAYMENT OF CHARGES. I ALSO AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF THE INSURANCE COVERAGE, BUT AUTHORIZE THAT PAYMENT OF MEDICAL BENEFITS BE SENT DIRECTLY TO THE PROVIDER OF SERVICE.

PATIENT / PARENT OR GUARDIAN _____ DATE _____

CONFIDENTIAL

FOR PHYSICIAN'S EYES ONLY

DR. LOREN E. ROSENTHAL, MD.

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
Grandmother (mom's)	[ ]	[ ]		
Grandfather (mom's)	[ ]	[ ]		
Grandmother (dad's)	[ ]	[ ]		
Grandfather (dad's)	[ ]	[ ]		
Father	[ ]	[ ]		
Mother	[ ]	[ ]		
Sister / Brother	[ ]	[ ]		
Sister / Brother	[ ]	[ ]		
Sister / Brother	[ ]	[ ]		
Sister / Brother	[ ]	[ ]		

SOCIAL HISTORY

Occupation: _____

Marital Status: [ ]single [ ]married [ ]divorced [ ]widowed

Do you have Children? [ ]yes [ ]no If so, how many _____

Do you live alone? [ ]yes [ ]no If no, who lives with you? _____

Do you smoke? [ ] Yes, I smoke ____ pack(s) of cigarettes per day for ____ year(s)

[ ] Yes, I smoke cigars or a pipe.

[ ] No, I have never smoked.

[ ] No, I quit ____ years ago.

Do you drink alcohol? [ ]yes, [ ]daily [ ]1 or more times per week [ ]1 or more times per month

[ ]no, Never/rarely

[ ]no, but I used to.

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:

Constitutional			
Fever	[ ] Yes	[ ] No	
Weight Loss	[ ] Yes	[ ] No	
Excessive Fatigue	[ ] Yes	[ ] No	
Night Sweats	[ ] Yes	[ ] No	
Eyes			
Wear Glasses	[ ] Yes	[ ] No	Date of Last Exam: _____
Infections	[ ] Yes	[ ] No	
Injuries	[ ] Yes	[ ] No	
Glaucoma	[ ] Yes	[ ] No	
Cataracts	[ ] Yes	[ ] No	
Ear, Nose, Throat and Mouth			
Wear Hearing Aids	[ ] Yes	[ ] No	Date of Last Exam: _____
Hearing Loss	[ ] Yes	[ ] No	
Ear Pain	[ ] Yes	[ ] No	
Ear Infections	[ ] Yes	[ ] No	
Ringing in Ears	[ ] Yes	[ ] No	Circle: Left Right Both
Imbalance	[ ] Yes	[ ] No	(e.g. vertigo, spinning)
Nosebleeds	[ ] Yes	[ ] No	
Nasal Congestion	[ ] Yes	[ ] No	
Nasal Drainage	[ ] Yes	[ ] No	Amount: _____ Color: _____
Inability to Smell	[ ] Yes	[ ] No	
Sinus Problems	[ ] Yes	[ ] No	
Sinus Headaches	[ ] Yes	[ ] No	
Sore Throats	[ ] Yes	[ ] No	
Mouth Sores	[ ] Yes	[ ] No	
Cardiovascular			
Chest Pain or Angina	[ ] Yes	[ ] No	Date of Last EKG: _____
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	

Patient Name: _____ Date of Birth: _____

Respiratory

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: _____

Gastrointestinal

Indigestion or Pain w/ Eating	[ ] Yes	[ ] No	
Nausea	[ ] Yes	[ ] No	
Vomiting	[ ] Yes	[ ] No	
Blood in Vomit	[ ] Yes	[ ] No	
Liver Disease	[ ] Yes	[ ] No	
Jaundice	[ ] Yes	[ ] No	
Abdominal Pain	[ ] Yes	[ ] No	
Change in Bowel Habits	[ ] Yes	[ ] No	
Colon Cancer	[ ] Yes	[ ] No	

Genitourinary

Urinary Tract Infections	[ ] Yes	[ ] No	
Painful Urination	[ ] Yes	[ ] No	
Blood in 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	[ ] Yes	[ ] No	List: _____
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	

Patient Name: _____ Date of Birth: _____

Integumentary

- Skin Disease **[ ]** Yes **[ ]** No
- Skin Cancer **[ ]** Yes **[ ]** No
- Breast Pain, Tenderness or Swelling **[ ]** Yes **[ ]** No
- Nipple Discharge **[ ]** Yes **[ ]** No
- Date / Result of Last Mammogram (females) **[ ]** Yes **[ ]** No Date / Result: _____

Neurological

- Fainting Spells / "Blacking out" **[ ]** Yes **[ ]** No
- Seizures **[ ]** Yes **[ ]** No
- Problems with Memory **[ ]** Yes **[ ]** No
- Disorientation **[ ]** Yes **[ ]** No
- Difficulty with Speech **[ ]** Yes **[ ]** No
- Inability to Concentrate **[ ]** Yes **[ ]** No
- Double or Blurred Vision **[ ]** Yes **[ ]** No
- Face Weakness **[ ]** Yes **[ ]** No
- Coordination in Arms and/or Legs **[ ]** Yes **[ ]** No

Psychiatric

- Anxiety **[ ]** Yes **[ ]** No
- Depression **[ ]** Yes **[ ]** No
- Other Psychiatric Disorder / Treatment: _____

Endocrine

- Diabetes **[ ]** Yes **[ ]** No
- Thyroid Disease **[ ]** Yes **[ ]** No
- Increased Appetite **[ ]** Yes **[ ]** No
- Excessive Thirst or Urination **[ ]** Yes **[ ]** No
- Hormone Problems **[ ]** Yes **[ ]** No
- Arthritis **[ ]** Yes **[ ]** No

Hematologic / Lymphatic

- Anemia **[ ]** Yes **[ ]** No
- Hemophilia **[ ]** Yes **[ ]** No
- Bleeding Tendencies **[ ]** Yes **[ ]** No
- Persistent Swollen Glands / Lymph Nodes **[ ]** Yes **[ ]** No
- Blood Transfusion **[ ]** Yes **[ ]** No When? _____
- Arthritis **[ ]** Yes **[ ]** No

Allergic / Immunologic

- Food Allergies **[ ]** Yes **[ ]** No
- Inhalant (nasal) Allergies **[ ]** Yes **[ ]** No
- Immunologic Disorders **[ ]** Yes **[ ]** No

Patient Name: _____ Date of Birth: _____

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) and Signature Date

_____ _____

Physician Name (Printed) and Signature Date

_____ _____

Physician Name (Printed) and Signature Date

_____ _____

Physician Name (Printed) and Signature Date

_____ _____

Physician Name (Printed) and Signature Date