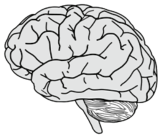

Tennessee Valley Neurological Associates

PLEASE PRINT **(Please use Black or Blue Ink ONLY)** **Patient Information Form**

Patient Name: ____________________ Date: __________

Address: ____________________ City: __________ State: __________ Zip: __________

Referring Physician: ____________________ Family Physician: ____________________

Home Phone: ( ) ____________________ Cell Phone: ( ) ____________________

Work Phone ( ) ____________________ Ext. ______ Preferred Contact: ☐ Home Phone ☐ Cell Phone ☐ Letter

SS#: ______ - ______ - ______ Sex: M or F Age: ______ Date of Birth: ______ / ______ / ______

☐Married ☐Divorced ☐Separated ☐Widowed ☐Single Preferred Language ______ Email: ______________

Patient's Employer: ____________________ Occupation: ____________________

Employer's Address: ____________________

(Please provide Account Guarantor's Information, when the patient is a minor)

Spouse or Account Guarantor's Name: ____________________ Date of Birth: ______ / ______ / ______

SS#: ______ - ______ - ______ Occupation: ____________________

Employer: ____________________ Phone: ( ) ____________________

Notify In Case of Emergency: ____________________ Relationship: __________

Phone: ( ) ____________________ Cell Phone: ( ) ____________________

Notify In Case of Emergency: ____________________ Relationship: __________

Phone: ( ) ____________________ Cell Phone: ( ) ____________________

Result of on the job injury: ______ **Result of Accident:** ______ **Date of Injury:** ______

(Provide Guarantor's Information only when patient is a minor otherwise provide patient's information) **PRIMARY INSURANCE**

Insurance Name:	Relationship to Patient:
Subscriber's Name:	Copay Amount:
Subscriber ID/Contract/Policy#:	Group#:
Subscriber's Social Security#:	Subscriber's Date of Birth:
Subscriber's Employer:	Employer's Phone:

SECONDARY INSURANCE

Insurance Name:	Relationship to Patient:
Subscriber's Name:	Copay Amount:
Subscriber ID/Contract/Policy#:	Group#:
Subscriber's Social Security#:	Subscriber's Date of Birth:
Subscriber's Employer:	Employer's Phone:

PERSON RESONSIBLE FOR THIS ACCOUNT ____________________ Phone: ( ) ____________________

When applicable, I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs, or attorney's fees. I authorize Huntsville Hospital Neurological Associates to release information to insurance carriers and for insurance carrier's to release information to Huntsville Hospital Neurological Associates concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignments applies.

Signature of Responsible Person ____________________ **Date** ______________ **Time:** __________

CHART # ________________

TVNA HISTORY AND PHYSICAL

Name | SS # | Date
Address | Date of Birth
Phone (Home) | (Work) | Email
Referring Physican | Primary Care Physican
Reason for visit

WHAT ARE YOUR MAIN CONCERNS OR QUESTIONS TODAY?

DESCRIPTION OF PRESENT ILLNESS

When did your symptoms start?

CURRENT MEDICATIONS

Name	Dose	Name	Dose

DRUG ALLERGIES

Medications | Reactions

1)
2)
3)

Latex Allergy: Y___ N___

PAST MEDICAL HISTORY

- ☐ Headache
- ☐ Epilepsy / Seizures
- ☐ Stroke
- ☐ Head Injury / Concussion / Whiplash
- ☐ Spinal Cord Injury
- ☐ Arthritis _______________ (type)
- ☐ Peripheral Nueropathy
- ☐ Brain Tumor
- ☐ Depression or Anxiety
- ☐ Coronary Artery Disease / MI
- ☐ Irregular Heartbeat / Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Murmur
- ☐ High Blood Pressure
- ☐ Fibromyalgia
- ☐ Cancer ______________ (type)
- ☐ Tuberculosis
- ☐ HIV / AIDS
- ☐ Alcohol Use:
- ☐ # drinks per day ________
- ☐ # drinks per year ________
- ☐ Smoking:
- ☐ Current or past smoker
- ☐ # packs per day ________
- ☐ # packs per year ________
- ☐ COPD / Emphysema
- ☐ Pneumonia
- ☐ Asthma
- ☐ GERD / Acid Reflux
- ☐ Colon Polyps
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Diabetes __________ (type)
- ☐ Peripheral Vascular Disease
- ☐ Thyroid Disease
- ☐ Menstrual / Sexual Dysfunction
- ☐ Other Endocrine
- ☐ Liver Disease / Hepatitis
- ☐ Kidney Problems
- ☐ Bladder Problems
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Allergy / Hay Fever
- ☐ Carotid Artery Disease
- ☐ Autoimmune Disease (Lupus, etc.)
- ☐ High Cholesterol
- ☐ Sleep Apnea
- ☐ Other ____________________

PAST SURGICAL HISTORY

- ☐ Amputation
- ☐ AV Fistula Creation
- ☐ AV Graft
- ☐ Aortic Valve Replacement
- ☐ Appendectomy
- ☐ Legs Bypassed Right / Left
- ☐ Back Surgery
- ☐ Bronchoscopy (Lung Scope)
- ☐ CABG (Heart Bypass)
- ☐ Carotid Endarterectomy
- ☐ Carpal Tunnel Right / Left
- ☐ Cataract Extraction
- ☐ Gallbladder Removed
- ☐ Colon Resection
- ☐ Craniotomy
- ☐ Gastric Bypass
- ☐ Hemorrhoidectomy
- ☐ Hip Replacement Right / Left
- ☐ Invasive Pain Procedure
- ☐ Kidney Transplant
- ☐ Knee Arthroscopy
- ☐ Knee Replacement Right / Left
- ☐ Kyphoplasty
- ☐ Lumpectomy
- ☐ Mitral Valve Replaced
- ☐ Nephrectomy
- ☐ Pacemaker Implanted
- ☐ Parathyroidectomy
- ☐ Pneumonectomy
- ☐ PTCA (Angioplasty)
- ☐ Rotator Cuff Repair Right / Left
- ☐ Abd. Hysterectomy
- ☐ Hysterectomy/Ovaries
- ☐ **Ovaries Removed Yes / No
- ☐ Prostate Surgery
- ☐ Shoulder Surgery Right / Left
- ☐ Sleep Apnea Surgery
- ☐ Thyroid Surgery
- ☐ Tonsil's Removed
- ☐ Vascular Surgery
- ☐ Breast Augmentation Right / Left
- ☐ Mastectomy Right / Left
- ☐ Lumpectomy Right / Left
- ☐ Other ____________________

____

Advanced Directives: Y____ N ____
(Please provide office a copy for their records)

REVIEW OF SYSTEMS

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Anorexia
- ☐ Fatigue
- ☐ Weakness
- ☐ Malaise
- ☐ Weight Loss
- ☐ Sleep Disorder

RESP
- ☐ Cough
- ☐ Dyspnea at Rest
- ☐ Excessice Sputum
- ☐ Coughing Up Blood
- ☐ Wheezing
- ☐ Shortness of Breath at Rest
- ☐ Emphysema/ Bronchitis
- ☐ Pneumonia
- ☐ Hemopysis

MS
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Stiffness
- ☐ Arthritis
- ☐ Sciatica
- ☐ Leg Pain at Night
- ☐ Leg Pain With Exertion
- ☐ Restless Legs
- ☐ Numbness/Tingling
- ☐ Varicose Veins
- ☐ Phlebitis

ALLERGY
- ☐ Hives
- ☐ Allergic Rash
- ☐ Hay Fever
- ☐ Recurrent Infections

BREAST
- ☐ Lumps
- ☐ Nipple Discharge
- ☐ Do Self Exam

GU
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Discharge
- ☐ Urinary Frequency
- ☐ Urinary Hesitancy
- ☐ Nightime Urination
- ☐ Incontinence
- ☐ Genital Sores
- ☐ Decreased Libido
- ☐ Erectile Disfunction
- ☐ Leakage of Urine
- ☐ Kidney Stones
- ☐ Frequent Infections

DERM
- ☐ Rash
- ☐ Itching
- ☐ Dryness
- ☐ Suspicious Lesions
- ☐ Hair/Nail Problems
- ☐ Lumps
- ☐ Masses

GI
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in Bowel Habits
- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Jaundice
- ☐ Gas/Bloating
- ☐ Indegestion/Heartburn
- ☐ Trouble Swallowing
- ☐ Painful Swallowing
- ☐ Ulcer
- ☐ Hemorrhoids
- ☐ Hepatitis

HEME
- ☐ Bruse Easily
- ☐ Difficulty Stopping Bleeds
- ☐ Enlarged Lymph Nodes
- ☐ Yellow Jaundice
- ☐ Family History of Bleeding
- ☐ Blood Transfusion

ENT
- ☐ Earache
- ☐ Ear Discharge
- ☐ Ringing of Ears
- ☐ Decreased Hearing
- ☐ Nasal Congestion
- ☐ Nosebleeds
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Allergies
- ☐ Sinus Trouble
- ☐ Goiter/Thyroid
- ☐ Swollen Glands

CV
- ☐ Chest Pains
- ☐ Palpitations
- ☐ Syncope
- ☐ Shortness of Breath on Exertion
- ☐ Orthopnea
- ☐ PND
- ☐ Peripheral Edema
- ☐ Murmur
- ☐ Chest Pain w/exercise
- ☐ Swelling of Ankles
- ☐ Last EKG_______

PSYCH
- ☐ Depression
- ☐ Anxiety
- ☐ Memory Loss
- ☐ Suicidal Ideation
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Phobia
- ☐ Confusion

EYES
- ☐ Blurring
- ☐ Double Vision
- ☐ Irritation
- ☐ Discharge
- ☐ Vision Loss
- ☐ Eye Pain
- ☐ Sensitivity to Light
- ☐ Cataracts
- ☐ Last Eye Exam _______
- ☐ Wear Glasses/Contacts

ENDO
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Excessive Urination
- ☐ Unusual Weight Change
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Diabetes

NEURO
- ☐ Headaches
- ☐ Dizziness

ALLERGIES
- ☐ Seasonal Allergies

PRIOR HOSPITALIZATIONS

Reason ____

____

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	BROTHER	SISTER	SON	DAUGHTER
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Sudden Death	☐	☐	☐	☐	☐	☐	☐	☐
Rheumatic Disease	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	BROTHER	SISTER	SON	DAUGHTER
Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐
Neuromuscular	☐	☐	☐	☐	☐	☐	☐	☐
Headaches /Migraine	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Disease	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Neuromuscular	☐	☐	☐	☐	☐	☐	☐	☐
TB	☐	☐	☐	☐	☐	☐	☐	☐
AIDS	☐	☐	☐	☐	☐	☐	☐	☐

Cancer Type? ______________________________

Completed by: ______________________________ Date: ____________________

REMARKS

____

____