

The Neurology Group, LLP
Health Questionnaire – To Be Completed By The Patient

Today's Date: _____

Name: _____ Date of Birth: _____

Referring Doctor: _____ Primary Care: _____

Home Telephone: _____ Work Telephone: _____

Reason for Visit: _____

Other Medical Conditions: _____

Surgeries: _____

Family History

Condition	Self	Father	Mother	Grandparents	Siblings	Children
Coronary artery disease						
Atrial Fibrillation						
Congestive Heart Failure						
Hypertension						
Asthma						
Obstructive Lung Disease						
Gastrointestinal						
Kidney Disease						
High Cholesterol						
Thyroid disorder						
Diabetes						
Arthritis						
Depression						
Anxiety Disorder						
Autoimmune Disease						
Migraine						
Epilepsy/Seizures						
Tremor						
Stroke						
Neuromuscular Disease						
Neuropathy						
Dementia						
Fainting						
Kidney Stones						
Parkinson's disease						
Restless Legs Syndrome						
Cancer						
Heart Valve Surgery						

Do you smoke? Yes No How much? _____
 Do you drink? Yes No How much? _____
 Are you a substance abuser? Yes No Which substance? _____
 Are you: Right-handed Left-handed
 Occupation: _____

Who do you live with? _____

The Neurology Group, LLP
Review of Systems

Patient Name: _____

DOB: _____

Today's Date: _____

Please fill out the following form to assist the neurologist and staff to aid in your diagnosis and treatment.
Circle any symptoms you have now or previously.

Systemic

Fatigue
Fever
Chills
Weight change

Head

Headache
Facial Pain
Sinus pain

Eye

Flashing lights
Light sensitivity
Eye pain
Blurry vision
Double vision

ENT

Earache
Hearing loss
Ringing in ears
Nose bleeds
Nasal discharge
Throat pain

Psychological

Anxiety
Depression
Insomnia

Cardiovascular

Chest pain
Fast heart rate
Palpitations

Pulmonary

Shortness of breath
Cough
Wheezing

Sleep Disorders (apnea, etc)

GI

Loss of appetite
Trouble swallowing
Heartburn
Nausea
Vomiting
Abdominal pain

GU

Urinary frequency
Incontinence
Kidney stones

Skin

Itching
Rash

Endocrine

Excess sweating
Excess thirst
Change in libido

Musculoskeletal

Joint pains
Back pain
Muscle aches
Pain in hands and feet

Neurologic

Tremors
Dizziness
Vertigo
Fainting
Weakness
Numbness
Convulsions
Confusion
Memory loss

Neck

Neck Pain
Neck Stiffness

The Neurology Group, LLP

Designation for Release of Medical Information to a Family Member, Friend or Legal Representative

Introduction

It is the physicians' responsibility to ensure that the physician-patient relationship is confidential. The Privacy Statement of The Neurology Group, LLP is the basis for how we treat your Protected Health Information. HIPAA allows physicians to use their professional judgment on disclosing certain PHI to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Drs. Beesley, Burdick, Calder, Corbett, Hart, Penc, Schoen, Storey and Verdini realize that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note the following points:

- Only one person can be designated for this role
- The designation is valid until you cancel it in writing
- If you designate no one, Upstate Neurology may not be able to release information to any family member or friend.

Designation Statement

I, _____, designate the following person to be able to speak to a physician at The Neurology Group, LLP, a nurse or other staff member, should it be necessary, on my behalf. I hereby give permission to The Neurology Group, LLP through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release The Neurology Group, LLP, its physicians and staff, from any claim of confidentiality in connections with the release of this information.

Name of Designated Person: _____

Relationship: _____ Phone Number _____ (home/work)

Patient's Name: _____ Patient's Account #: _____

Patient's Signature: _____

Date: _____ Witness: _____

I decline to designate another person to speak with my physician or clinical staff.

Patient's Signature: _____

Date: _____ Witness: _____