POLIN NEUROSURGERY

PATIENT DEMOGRAPHIC INFORMATION

Name:			**DOB:**	**Sex: M [ ] F [ ]**
Address:			**Home Phone:**	
			Cell Phone:	
City:	**State:**	**Zip:**	**Work Phone:**	
Pharmacy Name:			**Marital Status:** [ ] Married [ ] Single	
Pharmacy Phone:			[ ] Divorced [ ] Widow	
Email:			**Preferred Language:**	
Ethnicity: [ ] Hispanic or Latino [ ] Non-Hispanic or Latino				
Race: [ ] Asian [ ] American Indian or Alaska Native [ ] Black or African American				
[ ] White [ ] Native Hawaiian or Other Pacific Islander [ ] Patient Declined				
Employment Information: [ ] Employed [ ] Unemployed [ ] Retired [ ] Other				
Employer's Name:			**Occupation:**	
Referring Physician:			**Primary Physician:**	
Emergency Contacts				
Name:	Relationship:		Phone:	
Name:	Relationship:		Phone:	
Responsible Party (if patient is under 18)				
Name:			**Home Phone:**	
DOB:	**Address:**			
Employer:				
Primary Insurance:			**Secondary Insurance:**	
Insurance Name:			**Insurance Name:**	
ID#:			**ID#:**	
Group#:			**Group#:**	
Subscriber Name:			**Subscriber Name:**	
Relationship to Patient:			**Relationship to Patient:**	
Subscriber DOB:			**Subscriber DOB:**	
Work Related Injury: [ ] YES (complete section below) **[ ] NO**				
Insurance Name:			**Insurance Phone:**	
Claim Number:			**Date of Injury:**	
Employer at time of injury:				

Medical History Form

To help us better evaluate your condition, please complete the following form. If you have any questions, we will be glad to help you. Thank you.

Name: _____ DOB:_____

Please List Current Medications and Dose

_____ _____

_____ _____

_____ _____

_____ _____

Please List Medical Allergies and Corresponding Reactions

_____ _____

_____ _____

____I have no known allergies.

Past Medical History
(Please circle conditions that you have a history of)

Alcoholism	Blood Transfusions	Heart Pain /Angina	Lung Cancer	Severe Allergy
Anemia	Bowel Disease	Hepatitis A	Lung / Respiratory Disease	Skin Cancer
Anesthetic Complications	Breast Cancer	Hepatitis B	Mental Illness	Stroke / CVA Brain
Anxiety	Cervical Cancer	Hepatitis C	Migraines	Suicide Attempt
Arthritis	Colon/Rectal Cancer	High Blood Pressure	Osteoporosis	Tyroid Problems
Asthma	Depression	High Cholesterol	Prostate Cancer	Ulcer
Autoimmune Problems	Diabetes	HIV	Reflux / Gerd	Other Disease or Cancer
Birth Defects	Development Disorder	Kidney / Bladder Disease	Seizures / Convulsions	NONE of the Above
Bleeding Disease	Heart Attack	Liver Cancer	Sexually Transmitted Disease	
Blood Clots	Heart Disease	Liver Disease		

Past Surgical History

Type of Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

Family History
(Please circle conditions your family has a history of)

Family History Unknown	Bleeding Disorders	High Blood Pressure	Seizures / Convulsions
Alcoholism	Breast Cancer	High Cholesterol	Severe Allergy / Hives
Anemia	Colon /Rectal Cancer	Kidney / Bladder Disease	Stroke / CVA of Brain
Anesthetic Problems	Depression	Lung / Respiratory Disease	Thyroid Problems
Arthritis	Diabetes	Migraines	Other Disease or Cancer
Asthma	Heart Disease	Osteoporosis	None of the Above

Has your mother, grandmother or a sister developed heart disease before the age of 65? YES NO

Has your father, grandfather, or a brother developed heart disease before the age of 55? YES NO

Name: _____ DOB: _____

RISK FACTORS:

Tobacco Use

Are you exposed to passive (second hand) smoke? YES NO

How would you describe your cigarette smoking status? Current Previous Never

(If you marked Never, skip to next section)

At what age did you begin smoking? _____ If you quit smoking, at what age did you quit? _____

How many cigarettes do you currently smoke or did you previously smoke per day? _____

How many cigars or pipes do you smoke per week? _____

How many cans of smokeless/chewing tobacco do you use per week? _____

Drug Use

Do you use recreational drugs? YES Type: _____ NO

HIV High Risk Behavior

Do you have a history of?
IV Drug Use / More than one sexual partner / Unprotected Sexual Contact YES NO Prefer to Discuss with Physician

Alcohol Use

How often do you drink alcohol? Never or Number of drinks per week:_____

(If you marked Never, skip to next section)

What type of alcohol do you drink? Beer Wine Liquor

How many drinks do you have per occasion? _____

How often do you have more than five drinks per occasion? Never Rarely Occasionally Frequently

Habits

Do you drink caffeine-containing products? Coffee Tea Soft Drinks N/A

How many per day? _____

Do you exercise? Never Occasionally Frequently Times per Week: 1-2 3-4 4-6 7+

Types of Exercise Bicycling Running Swimming Walking Aerobics Other

How often do you wear a seatbelt? % of time used: 100% 75% 50% 25%

What is your sun exposure? Rare Occasional Frequent

Preventative Care (female only):

Date of last mammogram (approximate date ok) :_____
Date of last pap smear (approximate date ok): _____

Current Height: _____inches **Current Weight: _____pounds**

Name: _____ **DOB:** _____

STOP-Bang Scoring Tool

To detect suspected Obstructive Sleep Apnea (OSA)

Have you ever been diagnosed with OSA?	YES	NO
a. If YES, do you have a CPAP machine?	YES	NO
b. If YES, are you currently using the CPAP machine?	YES	NO

If you answered NO to the above question, please answer the questions below.

Snore	**Do you snore loudly?** *(Louder than talking or loud enough to be heard through closed doors)*	**YES**	**NO**
Tired	**Do you often feel tired, fatigued or sleepy during daytime?**	**YES**	**NO**
Observed	**Has anyone observed you stop breathing during your sleep?**	**YES**	**NO**
Pressure	**Do you have, or are you being treated for high blood pressure?**	**YES**	**NO**
BMI	**Is your BMI more than 35?** *(We can calculate Height_____ Weight_____)*	**YES**	**NO**
Age	**Are you over 50 years old?**	**YES**	**NO**
Neck	**Is your neck circumference greater than 17"(male) or 16"(female)?** *(We can measure)*	**YES**	**NO**
Gender	**Are you a male?**	**YES**	**NO**

If you answered YES to 3 more questions, you are at high risk of having obstructive sleep apnea (OSA). We will talk to you more during the visit about OSA increased risk when having surgery and when taking prescription narcotics. In addition, we'll send a letter to your PCP recommending further evaluation and consideration of sleep study.

Oswestry Pain Disability Questionnaire

Patient Name:_____ **DOB:_____**

Please complete this questionnaire. It is designed to tell us how your back pain affects your ability to function in everyday life.

Rate your **Back or Neck pain** (1=minimal pain and 10=worst pain):

0 1 2 3 4 5 6 7 8 9 10

Rate your **Limb Pain** (1=minimal pain and 10=worst pain):

0 1 2 3 4 5 6 7 8 9 10

Please answer each section below by checking the One Choice that applies the most to you at this time.

(You may feel that more than one of the statement relates to you at this time, but it is very important that you, but please check only one choice that best describes your problem at this time.)

Section 1: Pain Intensity
□ I can tolerate the pain I have without having to use pain killers.
□ The pain is bad but I manage without taking pain killers.
□ Pain killers give complete relief from pain.
□ Pain killers give moderate relief from pain.
□ Pain killers give very little relief from pain.
□ Pain killers have no effect on the pain and I do not use them.

Section 2: Personal Care
□ I can look after myself normally without causing extra pain.
□ I can look after myself normally but it causes extra pain.
□ It is painful to look after myself and I am slow and careful.
□ I need some help but manage most of my personal care.
□ I need help every day in most aspects of self-care.
□ I do not get dressed wash with difficulty and stay in bed.

Section 3: Lifting
□ I can lift heavy weights without extra pain.
□ I can lift heavy weights but it gives extra pain.
□ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned for example on a table.
□ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
□ I can lift only very light weights.
□ I cannot lift or carry anything at all.

Section 4: Walking
□ Pain does not prevent me walking any distance.
□ Pain prevents me walking more than 1 mile.
□ Pain prevents me walking more than 0.5 miles.
□ Pain prevents me walking more than 0.25 miles.
□ I can only walk using a stick or crutches.
□ I am in bed most of the time and have to crawl to the toilet.

Section 5: Sitting
□ I can sit in any chair as long as I like.
□ I can only sit in my favorite chair as long as I like.
□ Pain prevents me sitting more than 1 hour.
□ Pain prevents me from sitting more than 0.5 hours.
□ Pain prevents me from sitting more than 10 minutes.
□ Pain prevents me from sitting at all.

Section 6: Standing
□ I can stand as long as I want without extra pain.
□ I can stand as long as I want but it gives me extra pain.
□ Pain prevents me from standing for more than 1 hour.
□ Pain prevents me from standing for more than 30 minutes.
□ Pain prevents me from standing for more than 10 minutes.
□ Pain prevents me from standing at all.

Section 7: Sleeping
□ Pain does not prevent me from sleeping well.
□ I can sleep well only by using tablets.
□ Even when I take tablets I have less than 6 hours sleep.
□ Even when I take tablets I have less than 4 hours sleep.
□ Even when I take tablets I have less than 2 hours of sleep.
□ Pain prevents me from sleeping at all.

Section 8: Sex Life
□ My sex life is normal and causes no extra pain.
□ My sex life is normal but causes some extra pain.
□ My sex life is nearly normal but is very painful.
□ My sex life is severely restricted by pain.
□ My sex life is nearly absent because of pain.
□ Pain prevents any sex life at all.

Section 9: Social Life
□ My social life is normal and gives me no extra pain.
□ My social life is normal but increases the degree of pain.
□ Pain has no significant effect on my social life apart from limiting energetic interests such as dancing.
□ Pain has restricted my social life and I do not go out as often.
□ Pain has restricted my social life to my home.
□ I have no social life because of pain.

Section 10: Traveling
□ I can travel anywhere without extra pain.
□ I can travel anywhere but it gives me extra pain.
□ Pain is bad but I manage journeys over 2 hours.
□ Pain restricts me to journeys of less than 1 hour.
□ Pain restricts me to short necessary journeys under 30 minutes.
□ Pain prevents me from traveling except to the doctor or hospital.

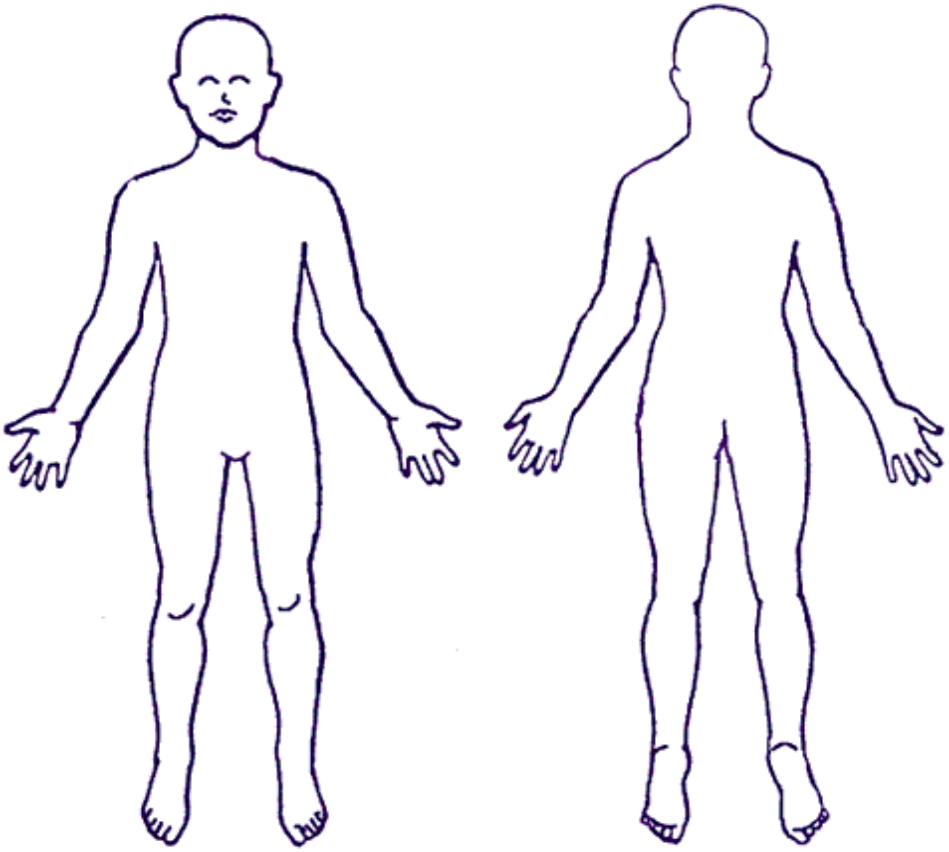
PAIN CHART

Patient Name: _____ **DOB: _____**

Current Problem Pain Diagram

Mark the area of your body where you feel painful sensations. Use the appropriate symbols::

Numbness, pins and needles, burning - 00
Aching, grabbing, cramping - XX
Shocking, stabbing, electric - \\



R **L** **L** **R**

When did symptoms start? _____

Review of Systems

Patient Name: _____ DOB: _____

General: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Fevers
- ☐ Appetite loss
- ☐ Fatigue (always tired)
- ☐ Chills
- ☐ Weight loss
- ☐ Sweats
- ☐ "feeling sick"
- ☐ None

Eyes: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Vision loss – 1 eye
- ☐ Vision loss – both eyes
- ☐ "halos" around lights
- ☐ Double vision
- ☐ Blurring
- ☐ Discharge
- ☐ Eye irritation
- ☐ Eye pain
- ☐ Light sensitivity
- ☐ None

Ears/Nose/Throat: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Ringing in the ears
- ☐ Decreased hearing
- ☐ Difficulty swallowing
- ☐ Ear discharge
- ☐ Nasal congestion
- ☐ Hoarseness
- ☐ Earache
- ☐ Nosebleeds
- ☐ Sore throat
- ☐ None

Cardiovascular: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Difficulty breathing at night
- ☐ Racing/skipping heart beats
- ☐ Shortness of breath with exertion
- ☐ Difficulty breathing while lying down
- ☐ Bluish discoloration of lips or nails
- ☐ Near fainting
- ☐ Fatigue
- ☐ Palpitations
- ☐ Fainting
- ☐ Weight gain
- ☐ Chest pain or discomfort
- ☐ Lightheadedness
- ☐ Swelling of hands or feet
- ☐ Leg cramps with exertion
- ☐ None

Respiratory: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Sleep disturbances due to breathing
- ☐ Coughing up blood
- ☐ Excessive sputum
- ☐ Cough
- ☐ Chest discomfort
- ☐ Excessive snoring
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ None

Gastrointestinal: (Mark all that apply; If no symptoms, please mark "none")

- ☐ Excessive appetite
- ☐ Vomiting blood
- ☐ Yellowing skin color
- ☐ Abdominal bloating
- ☐ Change in bowel habits
- ☐ Bloody stools
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Indigestion
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Dark tarry stools
- ☐ None

Genitourinary: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Foul urinary discharge
- ☐ Inability to empty bladder
- ☐ Trouble starting urinary stream
- ☐ Inability to control bladder
- ☐ Excessively heavy periods
- ☐ Other abnormal vaginal bleeding
- ☐ Blood in urine
- ☐ Urinary urgency
- ☐ Painful urination
- ☐ Genital sores
- ☐ Missed periods
- ☐ Pelvic pain
- ☐ Urinary frequency
- ☐ Kidney pain
- ☐ Night time urination
- ☐ Lack of sexual drive
- ☐ Unusual urinary color
- ☐ None

Musculoskeletal: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Muscle cramps
- ☐ Presence of joint fluid
- ☐ Muscle weakness
- ☐ Loss of strength
- ☐ Joint pain
- ☐ Back pain
- ☐ Arthritis
- ☐ Muscle aches
- ☐ Joint swelling
- ☐ Stiffness
- ☐ Gout
- ☐ None

Skin: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Excessive perspiration
- ☐ Changes in nail beds
- ☐ Unusual hair distribution
- ☐ Changes in color of skin
- ☐ Night sweats
- ☐ Dryness
- ☐ Skin cancer
- ☐ Flushing
- ☐ Suspicious lesions
- ☐ Poor wound healing
- ☐ Itching
- ☐ Rash
- ☐ None

Neurologic: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Difficulty with concentration
- ☐ Disturbances in coordination
- ☐ Falling down
- ☐ Visual disturbances
- ☐ Sensation of room spinning
- ☐ Excessive daytime sleeping
- ☐ Poor balance
- ☐ Numbness
- ☐ Tingling
- ☐ Seizures
- ☐ Tremors
- ☐ Memory loss
- ☐ Headaches
- ☐ Inability to speak
- ☐ Brief paralysis
- ☐ Weakness
- ☐ Fainting
- ☐ None

Psychiatric: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Sense of great danger
- ☐ Mental problems
- ☐ Frightening visions or sounds
- ☐ Anxiety
- ☐ Depression
- ☐ Thoughts of suicide
- ☐ Thoughts of violence
- ☐ None

Endocrine: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Excessive hunger
- ☐ Excessive urination
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Weight change
- ☐ none

Heme/Lymphatic: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Enlarged lymph nodes
- ☐ Abnormal bruising
- ☐ Bleeding
- ☐ Fevers
- ☐ Skin discoloration
- ☐ None

Allergic/Immunologic: (Mark all that apply; if no symptoms, please mark "none")

- ☐ Persistent infections
- ☐ HIV exposure
- ☐ Hives or rash
- ☐ Seasonal allergies
- ☐ None

Patient Consent for Use and Disclosure of Health Information

Patient Name:_____ DOB: _____

I hereby give my consent for **Richard Polin MD** to use and disclose protected health information about me to carry out treatment, payment, and health care operations.
(The Notice of Privacy Practices provided by Richard Polin MD describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Richard Polin MD reserves the right to revise its Notice of Privacy Practices at any time.

With this consent, Richard Polin MD may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Richard Polin MD may mail to my home or other alternative location any items that assist the practice in carrying out health care operations, such as appointment reminder cards and patient statements.

With this consent, Richard Polin MD may e-mail to my home or other alternative location any items that assist in carrying out health care operations, such as appointment reminders and patient statements.

I authorize the following individuals to have access to my protected health information:

_____

Name Phone Number Relationship

_____

Name Phone Number Relationship

I have the right to request that Richard Polin MD restrict how it uses or discloses my personal health information to carry out health care operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Richard Polin MD to use and disclose my personal health information to carry out health care operations.

I authorize having my photograph taken for my Electronic Medical Record.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Richard Polin MD may decline to provide treatment to me.

Insurance Authorization and Assignment

I attest that the insurance information I have given to the office is correct and true to the best of my knowledge. I hereby assign benefits to be paid to the doctor, and authorize Richard Polin MD to furnish information regarding my illness to my insurance carrier.

_____ _____

Patient's Signature or Legal Guardian **Date**

Relationship to Patient:_____