

NEW HAMPSHIRE NEUROSPINE INSTITUTE INITIAL CRANIAL EVALUATION

Today's Date: ___ / ___ / ___ Medical Record #: _____
 Last Name: _____ First Name: _____ Date of birth: ___ / ___ / ___
 Age: _____ Male Female Height: _____ ft _____ in. Weight: _____ lbs.
 Primary Care Physician (PCP): _____ Physician Specialists: _____
 Referred by: _____

History:

Date when symptoms began: ___ / ___ / ___

Briefly describe your symptoms: _____

Do you experience headaches? Yes No

If yes, frequency. Daily Weekly Monthly Other _____

Do you have any nausea and/or vomiting? Yes No

Any visual abnormalities? Yes No

If yes, double vision? Yes No Blurred vision? Yes No

Loss of vision? Yes No

Any hearing Loss? Yes No If yes: Right Left

Any dizziness? Yes No

Any facial numbness? Yes No Extremity numbness? Yes No

Difficulty with memory? Yes No

Any weakness? Yes No Arms: Yes Legs: Yes

Any trouble with balance? Yes No

Any seizures? Yes No

Any history of a stroke? Yes No

Any family history of intracranial aneurysms? Yes No

Have you been started on steroids? Yes No

Seizure medications? Yes No If so, which one? _____

What diagnostic tests related to your head/brain have you had: (fill in approximate dates {month/year})

MRI ___/___/___ CT Scan ___/___/___ EEG ___/___/___

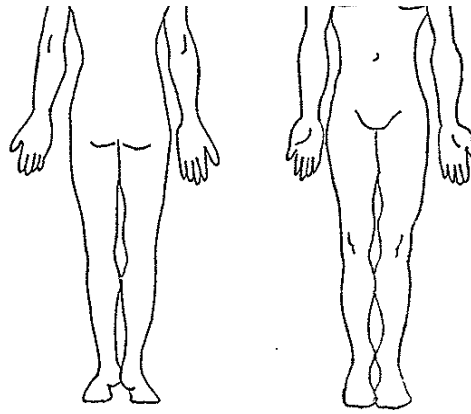
SHOW US WHERE YOUR PAIN IS LOCATED

Mark these drawings according to where you hurt

P = PAIN

N = NUMBNESS

(Numbness is the loss of sensation or the feeling of being "asleep" – it is not painful.)



Medical History: (check all that apply) Do you have or have you had any of the following?

No medical conditions

- Diabetes Heart Disease Stroke Asthma Depression Hepatitis High blood pressure
 Lung disease Alcohol abuse Ulcer disease Vascular disease Thyroid disease Osteoporosis
 Tuberculosis Arthritis High Cholesterol Anxiety ADD/ADHD GERD
 Cancer (type: _____) Other: _____

Have you had any previous surgery: (add dates) None

- Tonsils _____ Appendectomy _____ Gall Bladder _____
 Hysterectomy _____ Heart _____ Blood vessels _____
 Lung _____ Kidney _____ Stomach or intestinal _____
 Other(s): _____

List all of your current medications (Please include dose and frequency):

No medications

Pharmacy: _____

Location: _____

Do you have any drug allergies:

None

Yes List: _____

Social History:

Marital status: Single Married Divorced Separated Widowed

Do you have any children: No Yes (number: _____)

Living situation: Live with spouse Live with significant other Live alone Nursing home
 Live with parents Live with adult children Live with minor children

Smoking: Never smoked Quit _____ months ago Quit _____ years ago Yes _____ pks per day x _____ yrs.

Do you drink alcohol:

No Yes If yes, how much alcohol do you drink each day: _____ drinks/day.

Have you had any weight changes in the past year:

No Yes, gained _____ lbs. Yes, lost _____ lbs.

What is the last grade you completed:

_____ Grade GED High School Graduate 2-yr Associates Degree Technical School
 _____ yrs. College Bachelors Degree Post Graduate or Professional Degree

What is your race/ethnicity? : _____

What is your language preference of other than English? : _____

Family History:

Do any of these diseases run in your immediate family (parents, brothers and sisters only):

No medical conditions

- Diabetes Heart Disease Stroke Asthma Depression Hepatitis B High blood pressure
 Lung disease Alcohol abuse Ulcer disease Vascular disease Thyroid disease Arthritis
 Chronic Pain
 Cancer (type: _____) Other: _____

Work History: (Skip this section if already answered on page one.)

Present employer: _____

Primary occupation: _____

How long have you worked at your current job: _____ months _____ years

Current work situation:

- Working Paid leave Unpaid leave Unemployed Homemaker Student
Permanently disabled/retired due to back Permanently disabled/retired other health reasons
Retired not due to health

Exercise Habits:

Do you routinely exercise and if so how often? (Please describe):

Current Functional Status:

Which of these functions are you presently able to perform:

- Personal hygiene Cooking Light house cleaning (sweeping/dusting) Laundry
Heavy housework (vacuuming) Yardwork Driving _____ min. Sitting _____ min.
Walking _____ min. Standing _____ min. Lifting _____ lbs.

Review of Systems: Please check any condition you have experienced within the past year:

- | | | | |
|--|--|---|--|
| Recent nausea or vomiting <input type="checkbox"/> | Loss of hearing <input type="checkbox"/> | Frequent headaches <input type="checkbox"/> | Incontinence of bladder <input type="checkbox"/> |
| Hot or cold spells <input type="checkbox"/> | Nosebleeds <input type="checkbox"/> | Blackouts <input type="checkbox"/> | Incontinence of bowel <input type="checkbox"/> |
| Swollen ankles <input type="checkbox"/> | Stomach pain <input type="checkbox"/> | Seizures <input type="checkbox"/> | |
| Difficulty swallowing <input type="checkbox"/> | Ulcers <input type="checkbox"/> | Recent weight change <input type="checkbox"/> | |
| Morning cough <input type="checkbox"/> | Fever or chills <input type="checkbox"/> | Nervous exhaustion <input type="checkbox"/> | |
| Shortness of breath <input type="checkbox"/> | Constipation <input type="checkbox"/> | Claustrophobia <input type="checkbox"/> | |
| Heart or chest pain <input type="checkbox"/> | Poor appetite <input type="checkbox"/> | Pacemaker <input type="checkbox"/> | |
| Abnormal heartbeat <input type="checkbox"/> | Burning urination <input type="checkbox"/> | Metal in eye <input type="checkbox"/> | R or L |
| Calf cramps w/walking <input type="checkbox"/> | Recent diarrhea <input type="checkbox"/> | | |

If you check yes to any of the above, have you discussed the problem(s) with your primary care doctor?



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www.nhneurospine.com

Name: _____ Acct #: _____

Prescriptions and Medication Refills

Prescriptions and prescription refills are issued during regular business hours only. Our on-call physicians will not provide prescription refills or prescribe medications at night or on weekends.

- 1) You need to contact the office Monday- Friday 8am- 4pm. If you need a prescription refilled, please call the office and leave a message on our medication refill line by choosing option 4. Leave a detailed message and you will be contacted by one of our staff within 4 hours.
- 2) If you lose your prescription it will not be refilled until it was due for a refill.
- 3) You will need to take the medication as prescribed as it will not be refilled early in the event you decided to take more medication.
- 4) We will not automatically take over a narcotic prescription that has been prescribed by another provider.
- 5) Narcotics will not be prescribed on a long term basis and it is expected that medications will be weaned over time. In the event you are involved in our pain management program, you will be required to sign a "Pain Treatment Agreement" which will outline our policies and procedures for managing your pain.

I, the undersigned, acknowledge that I have read and understand the NHNSI prescription policy and procedure.

Signature: _____ Date: _____

E-Prescribing Consent

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- Formulary and benefit transactions - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that NHNSI can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to NHNSI to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Signature: _____ Date: _____

Uri Michael Ahn, MD - Spine Surgery ♦ Zubin S. Batlivala, MD - Psychiatry ♦ Eugene E. Berg, MD - Orthopaedic Surgery ♦ Thomas M. Frates, MD - Psychiatry ♦ Aron M. Jeffrey, DO - Psychiatry
N. Ross Jenkins, MD - Neurosurgery ♦ Thomas J. Kleeman, MD - Spine Surgery ♦ Robert A. Monighetti, MD - Psychiatry ♦ M. Rashidi, MD - Neurosurgery ♦ Adrian J. Thomas, MD - Spine Surgery

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MD USE ONLY

RX:

Vital signs:

MD Notes:
If minor who is accompanying?