Patient Centered Neurology at Mischer Neuroscience Associates
915 Gessner Road, Suite 750, Houston, Texas 77024
www.patientcenteredneurology.com

Patient Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Please indicate the best way to reach **you** by telephone below:

	Number	Best number to call
Home		
Work		
Cell		
Spouse's work		
Spouse's cell		

Healthcare Provider Information

Primary Care Physician: _____

Phone: _____

Who wants you to see a neurologist? _____

Emergency Contact

In case of emergency, whom should we contact? (This MUST BE someone other than you.) Please list all contact numbers.

Name	
Relationship	
Home	
Work	
Cell	

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Information Sharing

Persons who are involved in your care (family, friends, employer, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please list those persons (including family, friends, and employer) with whom you want us to share your information:

Name:	Relationship:

Pharmacy Information

Please list here the name, address, city and phone number of your pharmacy.

Pharmacy name	
Phone number	
Mail order pharmacy	
Phone number	

Insurance Information

Please provide current insurance information and identification when you check in for your appointment. Failure to provide accurate and current insurance information may result in patient responsibility for the entire bill.

Primary Insurance Company: _____

Insurance ID#: _____

Group #: _____

Second Insurance Company: _____

Insurance ID#: _____

Group #: _____

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Medical History

Cardiovascular
- ☐ Atrial fibrillation
- ☐ Heart Disease
- ☐ Heart attack
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Pacemaker
- ☐ Other: _____

Respiratory
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Other: _____

Gastrointestinal
- ☐ Hepatitis
- ☐ IBS
- ☐ GERD/Acid Reflux
- ☐ Other: _____

Genitourinary
- ☐ Kidney stones
- ☐ Recurrent UTI
- ☐ Other: _____

Musculoskeletal
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Other: _____

Endocrine
- ☐ Diabetes Mellitus
- ☐ Thyroid problems
- ☐ Other: _____

Neurology
- ☐ Dementia
- ☐ Memory Loss
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Migraines
- ☐ Epilepsy
- ☐ Cervical Spine Disease
- ☐ Lumbar Spine Disease
- ☐ Stroke/TIA
- ☐ Concussion
- ☐ Traumatic Brain Injury
- ☐ Brain/Spine Tumor
- ☐ Meningitis/Encephalitis
- ☐ Other: _____

Psychiatric
- ☐ Anxiety
- ☐ Alcoholism
- ☐ Depression
- ☐ Other: _____

Cancer
- ☐ Lung
- ☐ Brain
- ☐ Breast
- ☐ Cervical
- ☐ Kidney
- ☐ Uterine
- ☐ Other: _____

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Family History

Please indicate whether each family member is living or deceased and any/all medical history pertaining to that member.

Mother: _____

Father: _____

Paternal Grandfather: _____

Paternal Grandmother: _____

Maternal Grandfather: _____

Maternal Grandmother: _____

Siblings: _____

Children: _____

Other: _____

Social History

Please circle all that apply.

Highest level of education: HS GED Associate's Bachelor's Master's

Other:_____

Marital Status: Single Married Divorced Separated Widowed Partner

Occupation: _____

How long/often do you exercise?: _____

Tobacco Use: None Cigarettes Pipe Snuff Cigars

Current Previous Started?:_____ Quit?:_____

Alcohol Use: None Beer Wine Liquor

Drinks per day:_____ Drinks per week: _____

Caffeine Intake: None Coffee Tea Chocolate Energy Drinks

Drinks per day: _____

Drug Use: Never Current Prior

Which Drugs?:_____

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Past Surgery History

What surgery have you had performed in the past and approximately how long ago was it done?

			What year?
Example: Gall bladder	(Yes)	No	**1998**
Tonsillectomy	Yes	No	
Appendectomy	Yes	No	
Gall bladder surgery	Yes	No	
Intestinal surgery	Yes	No	
Heart surgery	Yes	No	
Other vascular surgery	Yes	No	
Joint replacement	Yes	No	
Cervical spine surgery	Yes	No	
Lumbar spine surgery	Yes	No	
Breast surgery	Yes	No	
Brain surgery	Yes	No	
Hysterectomy	Yes	No	
Other kidney disease	Yes	No	
Carpal tunnel surgery	Yes	No	
Plastic surgery	Yes	No	
Kidney stones surgery	Yes	No	
Other			
Other			
Other			
Other			

Please list **dates and locations** of any recent hospitalizations, labs or imaging you have had done. Please complete a medical records release form for each test pertaining to your appointment with Patient Centered Neurology at Mischer Neuroscience Associates.

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Medications/Treatment

Please list all of your medications including prescribed, over-the-counter, and supplements. Also list medication treatments that you receive in your doctor's office such as chemotherapy, CPAP, physical therapy and/or injections.

	Medication	Dose	When do you take it?
	Example: CPAP		**Every Night**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Allergies

List all medication sensitivities and allergies. Please list the reactions you have to the medications.

	Medication	Reaction
	Example: Penicillin	**Hives**
1		
2		
3		
4		
5		

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General review of systems

Have you had any of the symptoms listed below in the last year?

Fever		Shortness of breath	
Weight loss > 10 lbs.		Coughing up blood	
Weight gain >10 lbs.		Chest pain	
Trouble urinating		Palpitations	
New rashes or bumps		Joint deformity	
Breast lump		Joint pain	
Changing skin lesion		Change in thirst	
Inappropriate sadness or anxiety		Diarrhea	
Easy bruising		Change in vision	
Bleeding nose, ears, or mouth		Constipation	
Mouth sores		Abdominal pain	
Shortness of breath		Flank pain	

Neurological review of systems

Memory difficulty		Face pain	
Thinking problems		Pain in the shoulders arms/wrists	
Hallucinations		Pain in the hips legs or feet	
Confusion		Pain in the back of the neck	
Headaches		Low back pain	
Seizures		Mid back pain	
Difficulty speaking		Bladder/bowel control difficulty	
Difficulty swallowing		Numbness of the genitals or anus	
Double vision or loss of vision		Excessive daytime sleepiness	
Loss of hearing		Snoring	
Dizziness/vertigo		Tremor	
Numbness/tingling of arms/legs		Problems standing of balancing	
Numbness/tingling of face		Muscle tightening/spasm	
Weakness of the hands/arms/legs		Muscle shrinking	

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