Name________________________   Chart #_____________

BAPTIST HEALTH
NEUROSURGERY CLINIC

I, hereby acknowledge, that I am not pregnant and understand the risks of having ionizing radiation.

Date ___________

Signature ___________________________________

X-ray Tech __________________________________

PATIENT INFORMATION FORM

BAPTIST HEALTH NEUROSURGERY CLINIC

Parker Pavilion 2065 East South Boulevard, Suite 204
Montgomery, Alabama 36116-2463
PHONE: 334-747-7300 **FAX:** 334-747-7320

Name____

LAST FIRST MIDDLE

Date of Birth_____________ Age______ Sex______ Marital Status_______ SS Number_____________

Race_________ Language__________________ Caucasian____ Hispanic____ Other____

Address____________________________________ City, ST Zip________________________________

Phone: Home _______________ Cell_______________ (Carrier____________) Work_______________

Email____

Communication Preference: Patient Portal_____ Phone_____(Number_______________) Mail_____

Employer_______________________________ Address_______________________________________

Pharmacy Name____________________________________ Pharmacy Phone_____________________

Contact Person Not Living With You___________________________ Phone_______________________

Referring Physician_____________________________ Family Physician___________________________

Have you ever been treated by Donovan Kendrick, M.D. or Jeffry Pirofsky, D.O.?_____ When?________

INSURANCE INFORMATION

If Worker's Compensation/Name of Carrier____

Telephone____________________________ Contact Person_________________________________

I request that payment of authorized MEDICARE benefits be made on my behalf to UAB Medicine Neurosurgery for any services of items furnished to me by that supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Medicare Number________________________ Medicaid Number____________________________

OTHER INSURANCE

Name of Company________________________ Name of Insured ____________________________

Contract Number ________________________ Group Number_____________ Spouse DOB_______

I authorize the release of any medical information necessary to process any claim attached with this authorization. I hereby understand that I am financially responsible to the physician for charges. I request that insurance payments be made directly to UAB Medicine Neurosurgery.

Signed____ Date Signed___________________________

Date of Appointment: ____/____/____ Chart # __________________

UAB Medicine Neurosurgery ONLY: Reviewed by ___________________________ Date__________

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NAME ____ Referring Physician ___________________________

SOCIAL SECURITY # _________________________________ City, State __________________________________

DATE OF BIRTH ______________ AGE _________________ Family Physician _____________________________

OCCUPATION _____________________________________ Other Physicians _____________________________

MEDICAL HISTORY/CONSULTATION

CURRENT PROBLEMS

1. What is your main symptom? ____
2. When did it begin? ____
3. Is this problem related to your job? ☐ No ☐ Yes Describe if other than injury________________
4. Is your current problem related to an accident? ☐ No ☐ Yes If so, please describe it in detail (date, place, cause, injuries received, ER visits). Use the back of this page if needed. ________________________
   ____
   ____
5. Were any of your symptoms present before your accident? ☐ No ☐ Yes Which ones?____________
6. What other symptoms do you have and when did they begin? __________________________________
   ____
7. What test (electrical studies, x-rays, MRI, CT scan, myelogram, bone scan) have you had for these problems? (may circle) Other ____
   ____
8. Have you had physical therapy for this problem? ☐ No ☐ Yes ☐ Same ☐ Better ☐ Worse after
9. Have you had any spine injections for this problem? If so, what type (trigger point, epidural, nerve root blocks) and when?__________ What Physician?________________ ☐ Same ☐ Better ☐ Worse after
10. What other treatments have you had for this problem? Circle: (bed rest, chiropractor, massage, TENS unit, home traction, ice, heat, ointments) Other: ____
11. What medications are you <u>currently</u> taking for this problem?____________________________________
12. Is your problem getting better, worse, or is it unchanged?____
13. Have you had any other accidents or injuries that contributed to this problem? ☐ No ☐ Yes
    Describe____
14. Are you working currently? ☐ No ☐ Yes ☐ Usual Position ☐ Light duty
15. What dates have you missed from work because of this problem?____________________________
16. Have you hired an attorney regarding this problem? ☐ No ☐ Yes ☐ N/A

PATIENT HISTORY SHEET

UAB Medicine Neurosurgery ONLY: Reviewed by ____________________________ Date__________

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Patient:______________________________ DOB:_________________

For patients with pain: please circle any of the following that describe your symptoms.

Location – Head, face, Neck, Back (upper, middle, lower), Arm, Leg, left, right, both, Other ____________________

Quality – Sharp, Dull, Throbbing, Stabbing, Burning, Constant, Intermittent

Severity – Mild, Moderate, Severe, Varies

Timing – At night, awakens from sleep, with activity, when awakening in the morning

Circle any of the following that make your symptoms **WORSE**: Sitting, Standing, Walking, Twisting, Bending, Lifting, Work, Cough, Sneeze, Strain, Other____

Circle any of the following that make your symptoms **BETTER**: Sitting, Lying down, Standing, Medication, Ice, Heat, Other ____

SYSTEM REVIEW: Please check any of the following symptoms that you have experienced in the past six months, or check none at the end of each category.

GENERAL
- ☐ Weakness
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ NONE

SKIN
- ☐ Rash
- ☐ Cancer
- ☐ Itching
- ☐ NONE

HEAD
- ☐ Headache
- ☐ Trauma
- ☐ Dizziness
- ☐ Vertigo
- ☐ NONE

EYES
- ☐ Double Vision
- ☐ Blurred Vision
- ☐ Visual Loss
- ☐ Cataracts
- ☐ Glaucoma
- ☐ NONE

EARS
- ☐ Ringing
- ☐ Hearing Loss
- ☐ Drainage
- ☐ NONE

NOSE
- ☐ Bloody Nose
- ☐ Discharge
- ☐ Loss of Smell
- ☐ Facial Pain
- ☐ NONE

THROAT
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Trouble Swallowing
- ☐ NONE

NECK
- ☐ Pain
- ☐ Stiffness
- ☐ Mass
- ☐ NONE

HEART
- ☐ Chest pain
- ☐ Irregular Beat
- ☐ NONE

EXTREMITIES

	Numbness		*Weakness*	
Arm	☐L	☐R	☐L	☐R
Leg	☐L	☐R	☐L	☐R

- ☐ Ankle Swelling
- ☐ Blood Clot
- ☐ Arthritis
- ☐ Injury
- ☐ NONE

LUNGS
- ☐ Shortness of Breath
- ☐ Wheezing/Asthma
- ☐ Frequent Cough
- ☐ COPD/Emphysema
- ☐ NONE

GI
- ☐ Nausea
- ☐ Vomiting
- ☐ Reflux
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Loss of Bowel Control
- ☐ NONE

GU
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Loss of Bladder Control
- ☐ Blood in Urine
- ☐ NONE

BACK
- ☐ Pain
- ☐ Stiffness

BREAST
- ☐ Masses
- ☐ Pain
- ☐ Discharge
- ☐ NONE

NEURO/PSYCH
- ☐ Loss of Consciousness
- ☐ Weakness
- ☐ Tingling
- ☐ Seizures
- ☐ Balance Problems
- ☐ Frequent Falls
- ☐ Coordination Problems
- ☐ Difficulty Concentrating
- ☐ Poor Memory
- ☐ Excess Anxiety
- ☐ Depression
- ☐ Difficulty Speaking
- ☐ NONE

BLOOD
- ☐ Anemia
- ☐ Easy Bleeding
- ☐ On Blood thinner
- ☐ NONE

ENDOCRINE
- ☐ Thyroid Disease
- ☐ Heat/Cold Intolerance
- ☐ NONE

PATIENT HISTORY SHEET

Patient:______________________________ DOB:_________________

UAB Medicine Neurosurgery ONLY: Reviewed by ____________________________ Date___________

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PAST MEDICAL HISTORY: Please check any of the following problems that you have experienced in the past or now.

☐ Arthritis	☐ Gout	☐ Liver Problems	☐ Stroke
☐ Bleeding Problems	☐ High Blood Pressure	☐ Lung Problems	☐ TIA
☐ Cancer	☐ Headaches	☐ Lupus	☐ Ulcer Disease
☐ Depression	☐ Heart Attack	☐ Mental Problems	☐ Other_______ ____________
☐ Diabetes	☐ Epilepsy (Seizure)	☐ Osteoporosis	
☐ Drug Addiction	☐ Fibromyalgia	☐ Sickle Cell Disease	☐ None of These

SURGICAL HISTORY:

Have you had previous neck or lower back surgery? ____NO ____YES Surgeon_____________ When_________

What other operations have you had?____

____

Any problems with anesthesia? ____NO ____YES Describe ____

Have you had any other accidents or injuries in the past? ____NO ____YES Describe ____________________

____

MEDICATION: Please list all of your current medications and dosages.

Please include all over-the-counter medications such as Advil, Tylenol, herbal, vitamin, and weight-loss supplements

1. ______________________________ 6. ______________________________
2. ______________________________ 7. ______________________________
3. ______________________________ 8. ______________________________
4. ______________________________ 9. ______________________________
5. ______________________________ 10. ______________________________

ALLERGIES: Please list all medication or dye allergies and your reaction to each. ☐ **NO KNOWN ALLERGIES**

1. ______________________________ 4. ______________________________
2. ______________________________ 5. ______________________________
3. ______________________________ 6. ______________________________

FAMILY HISTORY: Please check any of the following diseases affecting your blood relatives.

☐ Arthritis	☐ Gout	☐ Liver Problems	☐ Sickle Cell Disease
☐ Bleeding Problems	☐ High Blood Pressure	☐ Lung Problems	☐ Stroke
☐ Cancer	☐ Headaches	☐ Lupus	☐ None of These
☐ Depression	☐ Heart Attack	☐ Mental Problems	
☐ Diabetes	☐ Epilepsy	☐ Muscular Dystrophy	

Are there any other problems that seem to run in your family? ____________________________________

SOCIAL HISTORY:

Last grade completed in school ___1-8 ___9-12 ___College ___Post graduate Marital Status: ___Single ___Married ___Separated ___ Divorced ___Widowed Use of Alcohol: ___Never ___Rarely ___Moderate ___Daily—Amount/Type______ Use of Tobacco: ___Never ___Previously, but quit ___Currently—packs/day_____--How long ___ years Recreational Drugs: ___Never ___Yes Types/Frequency________________________________	Have you applied for or are you on Social Security Disability? ☐ Yes ☐ No

VOCATIONAL HISTORY:

___Retired ___Unemployed ___Disabled ___Work Full-time ___ Work Part-time Last date you worked ___/___/___

Employer ____ How long? __________________________

Usual job duties____

Type ___Heavy Labor (up to 100lbs) ___Medium Labor (up to 50lbs) ___Light Labor (up to 20lbs) ___Sedentary (up to 10lbs)

Name____ Date___________________

PAIN SCALE **PAIN LOCATION**

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Circle the number that best describes your pain at the **PRESENT TIME**	Draw the location of your pain on the body illustrated below using these symbols: . . . Numbness /// Stabbing = = = Dull Ache **0 0 0** Pins & Needles **X X X** Burning
10 Pain as bad as it could be	RIGHT LEFT LEFT RIGHT RIGHT
9 Excruciating	
8	
7 Severe	
6	
5 Moderate	
4	
3 Mild	
2 Slight	
1	
0 No Pain	

FOLLOW-UP PATIENT HISTORY SHEET

UAB Medicine Neurosurgery ONLY: Reviewed by ____________________________ Date__________

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Today's Date: ___/___/___ Chart #_______________

Name____ DOB______________ Patient Phone:_________________

Address_________________________________ City_________________ Family Physician____________________

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE

1) What is your main symptom today? ____
2) In comparison to your last visit, how would you describe your condition? ___ Same ___ Better ___ Worse
3) What type(s) of treatment have you received since your last visit (Physical Therapy, Splints, Brace, Epidural Injections, Facet Blocks, etc.) ____
4) During the past week, how often have you taken prescription pain medication?

   ____ 3 or more times/day ____ 1-2 times/day ____ Once every other day ____ Once a week ____None
5) **SYSTEM REVIEW:** Please check any of the following symptoms that you are having today

☐ Fever	☐ Sore throat	☐ Chest Pain	☐ Balance Problems
☐ Chills	☐ Hoarseness	☐ Irregular Heart Beat	☐ Frequent Falls
☐ Wound Drainage	☐ Trouble Swallowing	☐ Shortness of Breath	☐ Coordination Problems
☐ Headache	☐ Neck Pain	☐ Wheezing/Asthma	☐ Difficulty Concentrating
☐ Dizziness	☐ Back Pain	☐ Frequent Cough	☐ Poor Memory
☐ Double Vision	*Numbness* *Weakness*	☐ Loss of Bowel Control	☐ Excess Anxiety
☐ Blurred Vision	Arm ☐L ☐R ☐L ☐R	☐ Loss of Bladder Control	☐ Depression
☐ Visual Loss	Leg ☐L ☐R ☐L ☐R	☐ Burning Urination	☐ Difficulty Speaking

6) Has there been any change in your Medical/Surgical History or Allergies since your last visit? ___NO ___YES

   Describe____
7) Since your last visit, have you been involved in any accidents or had any new injuries? ___NO ___YES

   Describe____
8) Please lit all your current medications ____

   ____
9) Are you currently working? ____ N/A ____NO ____YES ____Regular Duty ____Light Duty

   DATE RETURNED to work: ___/___/___
10) Please list any questions that you would like to have answered: ________________________________

    ____

    ____

    ____

    ____

    ____

PM & R FOLLOW-UP VISIT NOTE

UAB Medicine Neurosurgery ONLY: Reviewed by ___________________________ Date__________

BAPTIST HEALTH NEUROSURGERY CLINIC

Parker Pavilion 2065 East South Boulevard, Suite 204
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PHONE: 334-747-7300 **FAX:** 334-747-7320

Patient Name____ Date ___________________

Social Security Number ______________________________________ Date of Birth ________________________

Employer ____ Date of Injury/Onset __________________

Chief Complaint ____

Oswestry______Pain Drawing______ Pain Scale______ BP ______ Pulse ______ Resp ______ Wt ______ Ht______

CURRENT MEDICATIONS	PMHx/PSHx/FMHx/SocHx	ROS
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

INTERVAL HISTORY

EXAM

PROCEDURE NOTE

IMPRESSION:

1)____

2)____

3)____

4)____

PLAN:

1)____

2)____

3)____

4)____

Medications:____

Length of Appointment:_________________________ **Follow-Up Appointment:**_________________________

_____________________________________ Dictated ☐ YES ☐NO

Dr. Jeffry G. Pirofsky

CCs:____

UAB Medicine Neurosurgery ONLY: Reviewed by _____________________________ Date__________