**Patient Information Sheet**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Last: | First: | Middle: |
| Address: |  | Email: |
| City: | State: | Zip: |
| Home Phone: | Cell Phone: | Work Phone: |
| Sex: □ Male □ Female | Date of Birth: | Social Security Number: |
| Ethnicity: | Language Preference: | Race: |

**Advanced Directives: Please mark if you have any of the following (Please bring copies to first appointment)**

|  |  |  |  |
| --- | --- | --- | --- |
| □ | Healthcare Power of Attorney  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ | Living Will |
| □ | DNR Form (Do Not Resuscitate) | □ | Financial Power of Attorney |

**Next of Kin Information:**

|  |  |
| --- | --- |
| Name: | Relationship: |
| Address: | Email: |
| City: | State: Zip: |
| Home Phone: | Cell Phone: |

**Billing Address:**

|  |  |  |  |
| --- | --- | --- | --- |
| □ Same as patient | □ | Same as Next to Kin | |
| □ Other: |  |  | |
| **Pharmacy (and Location) and Phone #:** |  |  | |
| **Primary Care Physician’s Name:** | | | |
| Address:    City: State: Zip Code: | | | |
| Doctor’s Phone Number: | | | Fax: |
| **Names of Other Physicians:** | | | |

If you would like to receive reminders and/or confirmation regarding appointments, prescription refills or other information, **please note your preferred method of communication**. You may choose more than one. ❑ Voice Messages ❑ Email

I authorize Genesis Neuroscience Clinic to disclose my protected health information to the following family/ non-family member(s): ❑ Patient only

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the practice to disclose only the following protected health information to the individual(s) listed above:

\_\_\_\_\_\_\_\_\_ Test results, reports, and general health updates

\_\_\_\_\_\_\_\_\_ Appointment information only

Have you had any of the following brain/head scans: ❑ CT ❑ MRI ❑ PET ❑ N/A

If yes, date and location where it was performed. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary reason for your visit today:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Relative** | **Living?** | **Age** | **Illness/Cause of Death** |
| Mother | □ Y □ N |  |  |
| Father | □ Y □ N |  |  |
| Brother | □ Y □ N |  |  |
| Brother | □ Y □ N |  |  |
| Sister | □ Y □ N |  |  |
| Sister | □ Y □ N |  |  |

**Is there any history of:** **If so, who?**

Dementia: □ Y □N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alzheimer’s: □ Y □N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Memory Problem: □ Y □N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parkinson’s: □ Y □N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is there a history of abuse?**

Verbal □ Y □N

Sexual □ Y □N

Physical □ Y □N

**Patient’s Hospitalizations/Surgeries:**

|  |  |  |
| --- | --- | --- |
| **Date** | **Hospital** | **Type of Surgery/Reason for Hospitalization** |
|  |  |  |
|  |  |  |
|  |  |  |

**Patient’s Medical History: *Please check all that apply***

|  |  |  |
| --- | --- | --- |
| □ Heart disease | □ High cholesterol | □ Head Trauma |
| □ Stroke | □ High Blood Pressure | □ HIV |
| □ Parkinson’s | □ Cancer | □ Lyme’s disease |
| □ Depression | □ Seizure | □ Diabetes |
| □ Loss of Consciousness | □ Concussion |  |
| □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**Allergies:** □ No known allergies

Please list any known allergies and reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications:** Please bring all your prescription and non-prescription medications with you to this appointment **IN THE ORIGINAL BOTTLES.** Include eye drops, pills, nasal sprays, ointments, laxatives, herbals, supplements, vitamins, etc. Separate those that you use regularly from those that you only use as needed. List all medications you use regularly:

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dose/Strength** | **How Many? How many times per day?** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Social History:**

Do you have children? □ Y □ N How Many? \_\_\_\_\_\_\_\_\_\_

Are you or your spouse a veteran? □ Y □ N

Highest grade completed in school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your current or former occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Native language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Others spoken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Right or Left Handed? □ Right □ Left

Do you currently smoke? □ Y □ N

If *yes*, How long have you been smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many packs a day do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you quit smoking? □ Y □ N

If *yes*, When did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many years did you smoke prior to quitting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many packs a day did you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? □ Y □ N

If *yes*, What type, and how much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you used alcohol in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If *yes*, What type, and how much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you ever use illicit drugs? □ Y □ N

Do you exercise regularly? □ Y □ N

Did you get a flu shot this year? □ Y □ N

Marital status: □ Married □ Single □ Widowed □ Divorced

# of prior marriages\_\_\_\_\_\_\_\_\_

Spouse’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_