THE METROPOLITAN NEROSURGERY GROUP LLS

PATIENT REGISTRATION

Today's Date:_____/_____/_____	Primary Care Physician:

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI		
_____	_____	____	□ Mr. □ Mrs. □ Miss □ Ms.	□ Single □ Married □ Widow □ Divorce / Separate

DATE OF BIRTH _____/_____/_____	GENDER: □ M □ F	ETHNICITY (OPTIONAL) □ White □ African American □ Hispanic □ Asian □ Native American □ Other

ADDRESS

P.O. BOX:_____ or:
STREET ADDRESS:_____
CITY:_____STATE:_____ZIP:_____

SOCIAL SECURITY NO: _____-_____-_____	OCCUPATION:

HOME PHONE:	CELLULAR:	EMAIL:

Who referred you to us?	Who is your geneticist?	Send letter (visit note) to?

Preferred Pharmacy Name and Address:	Pharmacy phone no:

Height: _____'_____"	**Weight:** _____**lbs.**	**BP** (leave for staff): _____ /_____	**HR** (leave for staff): _____ **/** min

List the 3 top concerns that you would like to discuss today:

1_____
_____
2_____
_____
3_____
_____

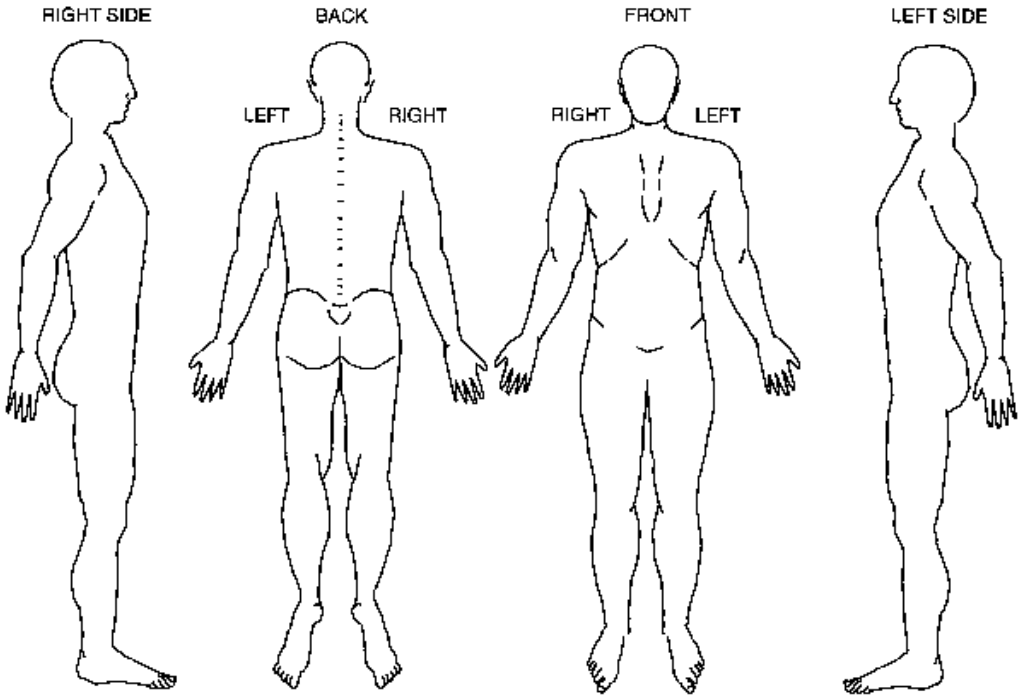
Imaging, tests or reports brought for review today:

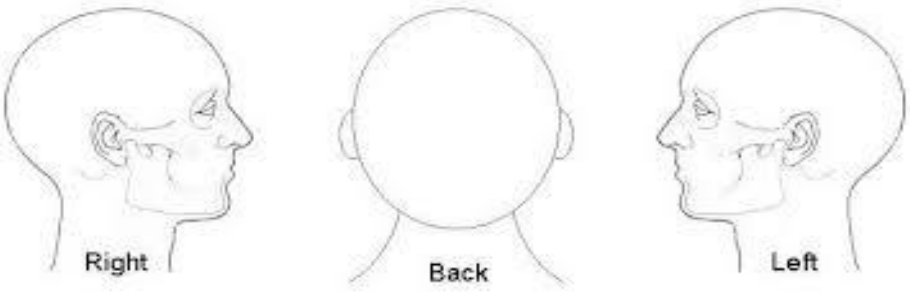
1_____**2**_____
3_____**4**_____
5_____**6**_____

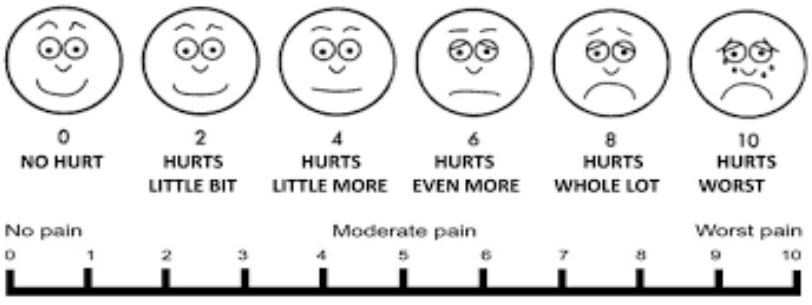
Patient Name:_____ **Date:_____**

PAIN ASSESSMENT:

Using the diagrams below, please indicate pain location, type, frequency and intensity.







PAIN TYPE:

+ aching **↓↓pins and needles**
♯ numb **● dull/throb**
▼ sharp **≈ nerve pain**

FREQUENCY

© continuous
≠ on and off

Patient Name:_____ **Date:**_____

PLEASE LIST ANY CONSERVATIVE TREATMENTS THAT YOU HAVE TRIED SO FAR:

PHYSICAL THERAPY:
Length of treatment and frequency:_____
Does your physical therapist specialize in EDS/Hypermobility?_____
Describe your response to treatment:_____
_____
_____

OCCUPATIONAL THERAPY:
Length of treatment and frequency:_____
Does your therapist specialize in EDS/Hypermobility?_____
Describe your response to treatment:_____
_____
_____

OTHER TYPES OF THERAPY (aqua, massage, dry needling, acupuncture, etc):
Type of procedure/treatment:_____
Length of treatment and frequency:_____
Does your therapist specialize in EDS/Hypermobility?_____
Describe your response to treatment:_____
_____
_____

NERVE BLOCKS AND EPIDURAL INJECTIONS: Date(s):_____
Type of block/injection_____
Describe your response to treatment:_____
_____
_____

OTHER PROCEDURES/TREATMENTS (BACLOFEN PUMP, TENS UNIT, etc.):
Type of procedure/treatment:_____
Length of treatment and frequency:_____
Describe your response to treatment:_____
_____
_____

BRACES: Type of brace:_____
Length of treatment and frequency:_____
Describe your response to treatment:_____
_____
_____

OTHER PROCEDURES, TREATMENTS OR MEDS (e.g. medications you have tried in the past for related symptoms, such as neurogenic bladder, chronic constipation/gastroparesis, nausea, POTS, etc).
_____
_____
Length of treatment and frequency:_____
Describe your response to treatment: _____
_____

Patient Name:_____ **Date:_____**

PLEASE LIST ALL MEDICATIONS THAT YOU HAVE TRIED FOR PAIN SO FAR:

NARCOTIC PAIN MEDICATIONS (e.g.: Oxycodone, Oxycontin, Dilaudid, Morphine Sulfate, Fentanyl patches, Percocet, Methadone, Marinol, etc) :

Drug			
Dose			
Frequency			
Length of treatment			
Response to treatment			

ORAL CORTICOSTEROIDS (e.g.: Medrol, Solucortef, Cortisone, Prednisone, Prednisolone, Methylprednisolone, Decadron, etc)

Drug			
Dose			
Frequency			
Length of treatment			
Response to treatment			

N.S.A.I.D.S (e.g.: Aspirin [Bufferin, Bayer, and Excedrin], Ibuprofen [Advil, Motrin, Nuprin], Ketoprofen [Actron, Orudis], Naproxen [Aleve], Daypro, Indocin, Lodine, Naprosyn, Relafen, Vimovo, Voltaren, Celebrex, Ketorolac, etc)

Drug			
Dose			
Frequency			
Length of treatment			
Response to treatment			

OTHER PAIN MEDICATIONS (e.g.: pain creams, lidocaine patches, Tylenol, etc)

Drug			
Dose			
Frequency			
Length of treatment			
Response to treatment			

Patient Name: _____ **Date:** _____

OTHER MEDICATIONS (please print)

Nr.	Medication	Dose	Frequency	Prescribing Physician	Taking since (year)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					

ALLERGIES

Nr.	Allergen	Reaction	Mild	Moderate	Severe
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Patient Name:_____ **Date:**_____

HISTORY

Social History (check all that apply)

Living arrangements	□ live alone □ does not live alone
Occupation/Exposure	□ agricultural □ office work □ other exposure
Activities of daily living	□ use a cane □ use a walker □ use a wheelchair □ problems using toilet □ no problems using toilet □ rely on others for transportation
Foreign travel/living	□ has recently traveled outside U.S.
Exercise	□ regularly □ occasionally □ rarely □ never
Education	□ currently attending school
Employment status	□ working full time □ working part time □ disabled □ retired □ not working

Smoking Hx:

□ active smoker: # of cigarettes/day: ___ for: ___ years.
□ former smoker: # of cigarettes/day: ___ for: ___ years; stopped: ___ years ago.
□ never smoked.

Alcohol consumption:

□ never
□ socially (2-3 times a year)
□ occasionally (2-3 times a month)
□ frequently (2-3 times a week)
□ 1 drink daily*
□ 2-3 drinks daily*
□ more than 3 drinks daily*

* one glass of wine/one beer/one shot glass of liquor are considered one drink.

Recreational drugs use:

□ current user: type of drug:_____ frequency: _____last time used:_____
□ former user: type of drug:_____ frequency: _____ last time used:_____
□ never used

Patient Name:_____ **Date:_____**

HAVE YOU EVER BEEN DIAGNOSED WITH:

Ehlers Danlos Syndrome (EDS) or other connective tissue disorder?

□ NO

□ YES: when did you experience the first symptoms? _____
any precipitating event? _____
year the diagnosis was made: _____ by: _____

Chiari Malformation?

□ NO

□ YES: when did you experience the first symptoms? _____
any precipitating event? _____
year the diagnosis was made: _____ by: _____

Tarlov Cyst?

□ NO

□ YES: when did you experience the first symptoms? _____
any precipitating event? _____
year the diagnosis was made: _____ by: _____

Other Medical History

ILLNESS	Onset (year)	Related to today's visit?

Patient Name:_____ **Date:**_____

Family History

Relative (e.g. mother, father, etc.)	**L**: living **D**: deceased	Age	Illness(s)

Surgical History

Surgery	Year

Patient Name: _____ **Date:** _____

REVIEW OF SYSTEMS (check all that apply)

NEUROLOGICAL	√	Lethargy		Shortness of breath on exertion	
Hyperaccusis/sensitivity to noise		Chronic pain		Feeling heart beats/palpitations	
Photosensitivity/light sensitivity		Back pain		Pain in legs while walking	
Hyper olfaction		Joint pain		Chronic cough	
Balance disorder		Anemia		Blood in sputum	
Vertigo		Multiple allergies		**GASTROINTESTINAL**	√
Dizziness/lightheadedness		Red eyes/burning eyes		Abdominal pain	
Shaking episodes		Fever		Black stool/blood in stool	
Seizures		Painful abscesses in mouth		Bloating	
Tremors		Skin sores		Blood in vomit	
Headache		Weight loss		Clay colored stool	
Neck pain		Weight gain		Constipation	
Loss of consciousness/syncope		Thyroid disorder		Diarrhea	
Memory loss		Swollen lymph nodes		Gall bladder pain	
Concentration difficulties		Heat intolerance		Distended veins	
Facial numbness		Nipple discharge		Heart burn	
Blurred vision		**MUSCULOSKELETAL**	√	Loss of bowel control	
Double vision		Fingers change color		Nausea	
Vision flashes		Urinary urgency/frequency		Unintentional weight loss	
Vision halos		Numbness in arms		**GENITOURINARY**	√
Foreign body sensation in eye		Numbness in legs		Frequent infections	
Ringing in the ears		Numb hands and feet		Burning sensation / urination	
Loss of hearing		Clumsiness		Dark yellow colored urine	
Speech difficulty		Frequent tripping		Flank pain	
Hoarseness		Osteoporosis		Unable to empty bladder	
Choking		Shoulder pain		Scoliosis	
Paresthesia/tingling/sensory loss		Burning pain trunk/arms/legs		Urinary hesitancy	
Leg weakness		Neck pain on bumpy roads		Increased frequency / urination	
Arm weakness		Lower back pain		Stress incontinence	
Nausea/vomiting		Pain in lower back and legs		Involuntary passage of urine	
Poor coordination		Bending over shopping cart		Nocturia (urination at night)	
Difficulty swallowing		Back pain standing/walking		Back pain walking up incline	
Nasal discharge		Back pain better when sitting		Sleep with knees bent	
CONSTITUTIONAL	√	Back pain when lying down		H/O sacral dimple	
Change in appetite		Muscle pain at rest		H/O delayed walking as infant	
Changes in sleep pattern		Cramps/stiff muscles		H/O pigeon toe	
Fatigue		Stiff back/can't bent forward		H/O toe walking	
Rashes		Sacral pain		H/O bedwetting (enuresis)	
Easily bruised		**CARDIOVASCULAR**	√	Flat feet	
Excessive bleeding		Chest tightness		**PSYCHIATRIC**	√
Poor wound healing		Chest pain at rest		Depression	
Frequent infections		Chest pain with activity		Anxiety/panic	
Coffee colored skin spots		Ankle swelling		Hallucinations	
Hair loss		Shortness of breath at night		Behavioral changes	
Excessive sweating		Shortness of breath at rest			

Patient Name:_____ **Date:**_____

OTHER PERTINENT INFORMATION YOU WOULD LIKE TO ADD: