Metropolitan Neurosurgery Group Associates

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Board Certified• Fellows of The American Association Of Neurological Surgeons

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(Please Check *(✓)* all that apply)

Prefix: Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ **DOB**: **AGE**: Blood Group: A+ve ☐ A-ve ☐ O+ve ☐ B+ve ☐ B-ve ☐ O-ve ☐ AB+ve ☐ Ab-ve ☐

First Name: **MI:** Gender: F ☐ M ☐ Race Group:
- American Indian or Alaskan native ☐
- Asian ☐
- Black or African American ☐
- Native Hawaiian or other Pacific islander ☐
- White ☐ Other ☐
- Declined ☐

Last Name: Ethnicity group: Hispanic or Latino ☐ Not Hispanic or Latino ☐

Suffix:

Jr. ☐	D.D.S. ☐	M.D. ☐	LVN ☐
Sr. ☐	II ☐	D.O. ☐	NP ☐

Preferred Language:

SSN:

Contacts Details

Address: City:
State: Zip: Country:

Phone No.: Cell No.:
Emergency No.: Work No.:
Email Address:

MODE OF REMINDER: EMAIL ☐ PHONE ☐ MAIL ☐ DO NOT CORRESPOND ☐ TEXT ☐

Emergency Details: Same as above? ☐

Prefix: Dr. ☐ Mr.☐ Mrs.☐ Ms.☐ DOB: _____

First Name: _____ Last Name: _____

Middle Initial: _____ Gender: F ☐ M ☐ Relationship: _____

Patient's occupation _____

Employer's name & Work address

_____

Spouse's name _____

Spouse's employer & work address _____

_____

Doctors seen in the past year or so:

_____

_____

_____

Insurance:

Primary insurance company name _____

ID# _____ **Group #** _____ **Phone** _____

Subscriber name _____ **SSN** _____ **Date of birth** _____

Secondary insurance company name _____

ID# _____ **Group #** _____ **Phone** _____

Subscriber name _____ **and SSN** _____ **and Date of birth** _____

Motor vehicle accident involved? _____ **Date** _____ **Auto insurance company** _____

Workers Comp accident involved? _____ **Date** _____ **W.C. carrier & phone** _____

Release and Assignment:

I authorize the release of any medical information necessary to process this claim. I hereby authorize Metropolitan Neurosurgery Group Associates, LLC or Bothwell G. Lee, M.D. to apply for benefits in my behalf for covered services rendered by him. I request that payments from my insurance company be made directly to Metropolitan Neurosurgery Group Associates, LLC or Bothwell G. Lee, M.D. I certify that the information I have reported with regard to my insurance coverage is correct, and that I will notify Metropolitan Neurosurgery Group Associates, LLC. of any change in coverage. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company in writing at any time.

Signature _____ **Date** _____

Last Name: _____ **First Name:** _____ **DOB:** _____

Today's date: _____

Describe the primary symptom prompting today's visit

Onset date; ever prior?; further details, symptoms, course, and treatment tried

Any known drug allergies and effect caused (if no known drug allergies, please write none)

Name	Effect and Severity (Enter Mild, Moderate or Severe)

Medications (including aspirin or Advil/ibuprofen-type medications) (List all medications)

Name of Medication	Dosage	Instructions	Prescribing Physician

Surgical History – List all

Type of Surgery	Date	Facility	Outcome

Hospitalization History - List all

Date	Reason

Last Name: _____ **First Name:** _____ **DOB:** _____

Today's date: _____

Medical History – List all

Date	Illness	Status (Check mark ✓)	Duration	Treatment
		☐ Chronic ☐ In recent past ☐ New onset ☐ Resolved ☐ Remote History		
		☐ Chronic ☐ In recent past ☐ New onset ☐ Resolved ☐ Remote History		
		☐ Chronic ☐ In recent past ☐ New onset ☐ Resolved ☐ Remote History		
		☐ Chronic ☐ In recent past ☐ New onset ☐ Resolved ☐ Remote History		
		☐ Chronic ☐ In recent past ☐ New onset ☐ Resolved ☐ Remote History		
Other		☐ Chronic ☐ In recent past ☐ New onset ☐ Resolved ☐ Remote History		

Family history – List all

Illness	Family Member (Relation)	Age	Deceased/Living
Stroke			
Bleeding disorder			
High blood pressure			
Diabetes			
Dementia			
Seizures			
Cancer			
Brain aneurysm			
Arthritis			
Heart attack			
Brain Tumor			
Other			
Other			
Other			

Last Name: _____ **First Name:** _____ **DOB:** _____

Today's date: _____

Social History (Check (✓) all that applies)

Living arrangements	**Occupation/Exposure**	**Activities of Daily Living**	**Foreign Travel/Living**	**Education**	**Employment status**	**Exercise**
☐ Live alone ☐ Does not live alone	☐ Agricultural ☐ Office work ☐ Other _____	☐ Use a cane ☐ Use a walker ☐ Use a wheel chair ☐ Have problem using bathroom ☐ Does not have problem using bathroom	☐ Has recently traveled outside of U.S.	☐Currently attending school	☐ Working full time ☐ Working part time ☐ Disabled ☐ Retired ☐ Not working ☐ Currently attending school	☐ Regularly ☐Occasionally ☐ Rarely ☐ Never

Active Consumption Records (Check (✓) all that applies)

Type	**Value**	**Quantity**	**Frequency**	**Duration**	**Status**
Smoking	☐ Cigarettes ☐ Cigars	☐ 1/2 pack ☐ 1 pack ☐ 2 packs or more	☐Never ☐ Occasionally ☐ Rarely		☐ Current-daily- smoker ☐ Current somedays smoker ☐ Former smoker
Alcohol	☐Wine ☐ Beer ☐ Hard Liquor	☐Wine: 1, 2, 3 glass per day ☐ Beer: 1, 2, 3 bottles per day ☐ Hard liquor 1.2oz/3oz per day	☐Never ☐ Occasionally ☐ Rarely		☐Active ☐ Quit ☐ No
Caffeine	☐Coffee ☐ Energy Drinks ☐ Pain Relievers ☐ Tea	☐ 1/2 Servings per day ☐ 2-4 Servings per day ☐ 4-8 Servings per day	☐Never ☐ Occasionally ☐ Rarely		☐Active ☐ Quit ☐ No
Recreational Drugs	Type _____		☐Never ☐ Occasionally ☐ Rarely		☐Active ☐ Quit ☐ No

Last Name: _____ **First Name:** _____ **DOB:** _____

Today's date: _____

Review of systems/CONSTITUTIONAL ***(Enter Y for yes and N for no)***

___Change in appetite ___Changes in sleep pattern ___Excessive sweating ___Poor Appetite ___ Poor Sleep ___Chest pain	___ Poor Energy ___Weight Loss ___ Fevers ___Depression ___Heart attack	___Fatigue ___Other lung disease ___Tuberculosis ___Bleeding trouble ___ Easily bruised	___ Weight Change ___Pregnant now? ___Peripheral Vascular ___Hepatitis ___HIV/AIDS _____Ulcers

Review of systems/Eyes, Ears, Nose, Mouth, Throat ***(Enter Y for yes and N for no)***

___ Blurred vision ___ Double vision ___ Burning of eyes ___ Change in vision ___Choking ___ Difficulty chewing ___Difficulty Swallowing ___ Difficulty tasting	___ Ear pain ___ Enlarged tonsils ___ Facial numbness ___ Foreign body sensation in eye ___ Frequent headaches ___ Hoarseness ___Loss of hearing	___ Mouth sores ___ Mucosal Ulcers ___ Nasal discharge ___Red eyes ___Ringing in the ears ___ Tinnitus ___ Vision flashes ___ Vision halos

Review of systems/CARDIOVASCULAR ***(Enter Y for yes and N for no)***

___ Ankle swelling ___ Chest pain ___ Chest tightness	___ Shortness of breath at night ___ Shortness of breath at rest ___ Shortness of breath on exertion

Review of systems/RESPIRATORY ***(Enter Y for yes and N for no)***

___ Blood in sputum	___ Chronic Cough

Review of systems/GASTROINTESTINAL ***(Enter Y for yes and N for no)***

___ Abdominal pain ___ Black stool-stool in blood ___ Bloating ___ Blood in vomit	___ Clay colored stools ___ Constipation ___ Diarrhea ___ Distended veins	___Heart Burn ___ Loss of bowel control/incontinence ___Nausea ___ Unintentional weight loss

Review of systems/GENITOURINARY ***(Enter Y for yes and N for no)***

___ Burning sensation during urination ___ Dark yellow colored urine ___ Flank pain	___ Frequency ___ Nocturia ___ Urgency

Review of systems/MUSCULOSKELETAL (Check (✓) all that applies)

___ Lower back pain ___Neck pain ___ Stiffness

Last Name: _____ **First Name:** _____ **DOB:** _____

Today's date: _____

Review of systems/SKIN AND/OR BREAST ***(Enter Y for yes and N for no)***

___Painful abscesses in the mouth ___ Rash ___Skin sores

Review of systems/HEMATOLOGIC/LYMPHATIC ***(Enter Y for yes and N for no)***

___ Bruising ___ Excessive bleeding ___Frequent infections

Review of systems/NEUROLOGICAL ***(Enter Y for yes and N for no)***

___ Balance disorder ___ Concentration difficulties ___Confusion ___ Depression	___ Dizziness and lightheadedness ___ Memory loss ___Seizures ___ Headache	___Tremors ___ Vertigo ___ Weakness of limbs ___ Numbness and tingling

Review of systems/PSYCHIATRIC ***(Enter Y for yes and N for no)***

___ Depression ___Hallucinations

Review of systems/ENDOCRINOLOGY ***(Enter Y for yes and N for no)***

___ Erectile dysfunction **(MALE – ONLY)** ___ Anxiety ___ Appetite changes ___ Breast pain ___ Bulging eyes	___ Changes in bowel habits ___ Changes in skin pigmentation ___Dark spots on skin ___ Excessive hunger ___ Excessive thirst	___Excessive urination ___ Fatigue ___Hair loss ___ Heat intolerance ___ Loss of Appetite ___ Muscle Spasms	___Nipple discharge ___ Palpitations ___ Swelling in neck midline ___ Weight gain ___ Weight loss ___ White spots on skin

Notes: