NASHVILLE NEUROSURGERY ASSOCIATES

Date of visit: _____ Email Address: _____

Patient Name: _____

Date of Birth: _____ SS#: _____ Sex: ___Female ___Male

Address: _____

City:_____ State:_____ Zip_____

Phone Numbers: (H) _____ (W) _____(C) _____

Check all that apply: Message can be left on [ ] H [ ] W [ ] C Message may be: [ ] Brief [ ] Extended

Height: _____ ft. _____in. Weight: _____ lbs. Hand Dominance: □ Right Handed □ Left Handed

RACE: Please check one (optional)

__American Indian or Alaska Native
__Asian
__Native Hawaiian or other Pacific
__Black or African American
__White
__Hispanic or Latino
__Other_____
__Declined to Answer

PRIMARY LANGUAGE:

__English __Spanish
__Arabic __Chinese
__French __Italian
__Other:_____

Marital status: [ ] Married [ ] Widowed [ ] Separated [ ]Divorced [ ] Single [ ] Partnership

HEALTH INSURANCE INFORMATION:

Primary Insurance: _____ Policy #:_____

Address: _____ Group #:_____

Phone: _____ Name of Insured: _____ DOB _____SSN_____

Employer of Policyholder: _____

Secondary Insurance: _____ Policy #:_____

Address: _____ Group #:_____

Phone: _____ Name of Insured: _____ DOB _____SSN_____

Employer of Policyholder: _____

------OR------

Are your symptoms due to a work-related accident? [ ] Yes [ ] No

WORKER'S COMPENSATION INFORMATION:

Insurance Carrier: _____ Claim #:_____Date of Injury: _____

Address: _____ Employer: _____

Phone: _____ Adjustor's Name: _____ Phone: _____

Patient Name: _____ DOB: _____

WHO REFERRED YOU TO OUR OFFICE?

Physician Name: _____ Specialty: _____

Address: _____

Phone Number: _____ Fax Number: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN?
[ ] SAME AS REFERRING DOCTOR ABOVE

Physician Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

PLEASE LIST ALL OTHER PHYSICIANS WHO SHOULD RECEIVE A COPY OF OUR REPORT:
[For Example: Cardiologist, Endocrinologist, Oncologist or Pulmonologist]

(1) Name: _____

Address: _____

Phone: _____

Fax: _____

(2) Name: _____

Address: _____

Phone: _____

Fax: _____

PLEASE LIST ANY OTHER PERSONS YOU WISH TO HAVE ACCESS TO YOUR MEDICAL INFO:
[For Example: Family, Friends or Attorney]

I authorize Nashville Neurosurgery Associates to contact and discuss my Personal Health Information with the following persons:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

X_____ _____
Patient Signature Date

Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS:

Please check all conditions that applies to you now OR in the past 6 months:

GENERAL:

- O Weight loss or gain
- O Chest pain
- O Change in appetite
- O Altered taste or smell
- O Heart murmur
- O Chest pressure
- O Angina
- O Fainting
- O Excessive sleepiness
- O Low blood pressure
- O Unable to sleep
- O Fatigue
- O Leg swelling

EARS, NOSE & THROAT:

- O Mouth sores
- O Sinus disease
- O Sore throat
- O Ringing in ears
- O Hearing loss
- O Cataracts
- O Blurred vision
- O Double vision

RESPIRATORY:

- O Shortness of breath
- O Trouble breathing
- O Emphysema
- O Tuberculosis
- O Chronic cough

GENITOURINARY:

- O Sexual dysfunction
- O Impotence
- O Kidney stones
- O Urinary incontinence
- O Urinary urgency
- O Vaginal bleeding
- O Frequent urination
- O Painful urination
- O Blood in urine

PSYCHIATRIC:

- O Anxiety
- O Depression
- O Trouble concentrating

GASTROINTESTINAL:

- O Ulcer
- O Vomiting
- O Constipation
- O Diarrhea
- O Bowel Incontinence
- O Hiatal hernia
- O Reflux
- O Rectal bleeding

NEUROLOGICAL:

- O Headache
- O Seizure
- O Memory loss
- O Loss of consciousness
- O Weakness
- O Falling down
- O Vertigo
- O Concussion

MUSCULOSKELETAL:

- O Low back pain
- O Neck pain
- O Joint pain
- O Trouble walking
- O Joint swelling
- O Numbness

HEMATOLOGICAL:

- O Blood disorder
- O HIV
- O Enlarged lymph nodes
- O Hepatitis
- O Tingling leukemia
- O Sickle cell disease

Patient Name: _____ DOB: _____

PAST MEDICAL HISTORY:

- O GERD/Heartburn
- O Colon Polyps
- O Pancreatitis
- O Ulcerative Colitis
- O Hypertension
- O Coronary Artery Disease
- O Congestive Heart Failure
- O Atrial Fibrillation
- O Pacemaker
- O AICD (Defibrillator)
- O COPD
- O Diabetes
- O Thyroid Problems
- O Elevated Cholesterol
- O Stroke
- O Fibromyalgia
- O Arthritis
- O Chronic Back pain
- O Cancer
- O Kidney Failure
- O Heart Attack
- O Seizures
- O Glaucoma
- O Pneumonia
- O Aneurysm

PAST SURGICAL HISTORY:

- O Colonoscopy
- O EGD (Upper endoscopy)
- O Ulcer Surgery
- O Colon Surgery
- O Cholecystectomy
- O Appendectomy
- O Hemorrhoidectomy
- O Bypass Surgery
- O Heart Valve Replacement
- O Hysterectomy
- O Ovaries Removed
- O Breast Cancer Surgery
- O Spinal Cord Stimulator
- O Prostate Surgery
- O Back Surgery
- O Neck Surgery
- O Hip Surgery
- O Knee Surgery
- O Weight Loss Surgery
- O Brain Surgery
- O Intrathecal Pain Pump
- O Other: _____

Have you ever had a problem with anesthesia? O Yes O No

If yes, please explain:

Have you ever had a blood transfusion? O Yes O No

If yes, why?

FAMILY HISTORY:

- O Arthritis
- O Heart Attack
- O Heart Disease
- O Peripheral Vascular Disease
- O Hypertension
- O High Cholesterol
- O Diabetes Mellitus
- O Stroke
- O Cancer
- O Aneurysm
- O Other:_____

Patient Name: _____ DOB: _____

SOCIAL HISTORY:

Do you drink alcohol? O Yes O No

If yes, approximately how many drinks per week? _____

Do you smoke or vape? O Yes O No

If yes, how often? O every day O some days **If yes,** how many a day? _____

How soon after you wake do you smoke? _____

Are you interested in quitting? O Yes O No O Undecided

If you are a former smoker, how long has it been since you last smoked?

[ ] 1-3 months [ ] 3-6 months [ ] 6-12 months [ ] 1-5 years [ ] 5-10 years [ ] 10+ years

Work Status: O Full Time O Part Time O Retired O Homemaker O Student O Unemployed O Disabled

Occupation:_____

MEDICATIONS:

Please list all medications and dosage you are currently taking, including over the counter medications.
Please also include the length of time you have been taking any narcotic medications.

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

Do you take aspirin or any medicines that contain aspirin such as Ibuprofen or Motrin? If yes, please specify:
_____

PHARMACY:

Please provide the name and phone number of your pharmacy so that we may keep this information on file if needed.

Name: _____City:_____Phone:_____

Patient Name: _____ DOB: _____

PAIN MANAGEMENT:

Are you currently in Pain Management or receiving pain medications from another physician? O Yes O No

If yes, please list below the name and address this physician:

Name: _____ Address: _____

Phone: _____ Fax: _____

ALLERGIES:

Please list any known drug and/or food allergies.

Medication / Food	**Type of Reaction**

Patient Agreement for Prescribed Medications

I will submit to random pill counts and urine and/or blood drug tests as requested by my provider in order to monitor my treatment. I understand that the presence of any unauthorized substances may prompt referral for assessment of addiction and could result in discontinuation of further opioid and all other prescriptions. I also understand that failure to follow these rules may lead to dismissal from care by my provider.

I will not share, sell or otherwise permit others to have access to my medication and I will keep it in a secure location as I understand that medications reported as lost or stolen will not be refilled early.

By signing this document either in person or electronically, I voluntarily give my consent to prescription medication therapy and fully understand my responsibilities.

X_____ _____

Patient Signature Date

Patient Name: _____ DOB: _____

HISTORY OF PRESENT ILLNESS:

What is the reason for your visit today?

_____

How long have you had the problem?

_____

How severe is the problem?

_____

What type of symptoms are you experiencing?

_____

How often do your symptoms occur?

_____

How long do your symptoms last?

_____

Is there anything that makes the problem worse?

_____

Does anything make the problem better?

_____

Have you ever had treatment or surgery for this problem?

_____

Please rate your pain on a scale from one to ten. (1 being minor and 10 being severe)

1 2 3 4 5 6 7 8 9 10

PREVIOUS TREATMENT: (Check all that you have tried)

- ☐ Previous Surgery
- ☐ Physical Therapy
- ☐ Exercise Programs
- ☐ Chiropractor
- ☐ Brace or Wrist Splints
- ☐ Narcotic Pain Medication (Lortab, Percocet, Vicodin, Etc.)
- ☐ Anti-Inflammatory Medications (Motrin, Naproxen, Aspirin, Etc.)
- ☐ Steroidal Anti-Inflammatory Medications (Medrol Dose Pak, Depo-Medrol, Solu-Medrol, Etc.)
- ☐ Epidural Steroid Injections:

  How many times (number of injections)? _____ These provided relief for:

  - ☐ No Relief
  - ☐ 1 – 4 weeks relief
  - ☐ 5 – 8 weeks relief
  - ☐ 8+ weeks relief

Patient Name: _____ DOB: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #_____

I request and authorize _____

to release healthcare information of the patient named above to:

NASHVILLE NEUROSURGERY ASSOCIATES – The office of:

	Provider	Fax Number	Phone Number
	Arthur J. Ulm, MD	615-902-3980	615-320-0007
	Robert A. Mericle, MD	615-902-3982	
	Robbi L. Franklin, MD	615-902-3983	
	Chine Sp. Logan, DO	615-320-3183	
	Ivan T. Stoev, MD	615-902-3981	
	Christopher M. Storey, MD	615-383-6329	

	Provider	Fax Number	Phone Number
	L. Brett Babat, MD	615-320-3186	615-986-1256
	Khan W. Li, MD	615-320-4178	
	William R. Schooley, MD	615-320-4106	
	Rex E. Arendall, MD	615-327-8975	
	D. Timothy Lockney, MD	615-329-3044	

This request and authorization applies to:

☐ ALL healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

_____

☐ Other:

_____

_____

_____ _____

Patient Signature **Date Signed**