RIVERHILLS NEUROSCIENCE

Welcome!

Thank you for choosing Riverhills Neuroscience.

In order for our medical staff to prepare for your appointment,
we require the enclosed <u>Health History Forms</u> be completed immediately.
using one of the following options:

1 GO ONLINE: *(our preferred method - it's quick!)*
A few days before your appointment you will receive a text or email with a secure link to **Phreesia**, our online registration tool. Need more help? Call (513) 612-1111.

Or…

2 BY MAIL: *(please send within 3 days of receiving this letter)*
Complete the following Health History Forms & mail using the enclosed envelope. Failure to submit these forms early may delay or cancel your appointment.

Note: some specialties may require additional paperwork.

Important Reminders

- **Insurance Card & Photo I.D.**
  Bring both to your appointment.
- **Medication:** Bring a complete, up-to-date list of your medications.
  It's important that we have an accurate record of the medicines you are currently taking.
- **Insurance:** Some plans require a referral from your primary care physician to see a specialist.
  It's your responsibility to obtain such a referral – if required – or assume any uncovered costs.
- **Previous Tests:** For your evaluation to be complete, please bring copies of all prior testing pertaining to the problem for which you are being seen (blood tests, X-Rays, CT scans, MRI scans, EMGs, EEGs). **This includes actual films or CDs of images, as well as written reports** – or any other clinical information related to your current clinical concern.
- **Appointment :** If you're unable to keep your scheduled appointment, call (513) 612-1111.
  Please allow at least 24 hour notice for cancellations.

Thank you. We look forward to seeing you!

RIVERHILLS NEUROSCIENCE
Division of Neurology

Health History Form

Name _____

Social Security Number _____

Date of birth _____ Age _____

Phone _____

Emergency contact _____

_____

Physician _____

Date of Appointment _____

Primary Care Physician _____

PCP City/State _____

You are: ☐ Right handed ☐ Male ☐ Left handed ☐ Female

**List your allergies in this box:

Or check this box if you have no known allergies ☐

Who referred you? (internist, family practitioner, etc)

Name: _____

City, State ZIP: _____

What pharmacy do you use?

Name: _____

City, State ZIP: _____

☐ Check here if you do NOT want reports sent to your primary doctor or your referring doctor(s).

What problem brings you to the doctor today?

_____

_____

How long have you been bothered by this problem? _____

Please rate your pain on a scale of 0 to 10 (0 = no pain, 10 = worst possible pain) _____

What other doctors have you seen, related to your current problem? _____ ,

_____ , _____ , _____

What tests have you had, related to your current problem?

	When	Where
☐ MRI scan (image of brain, neck, or back)	_____	_____
☐ CT scan (image of brain, neck, or back)	_____	_____
☐ EMG (electrical test of nerves and muscles)	_____	_____
☐ EEG (brain wave test)	_____	_____
☐ _____		_____
☐ _____		_____

Patient Name _____ DOB_____

Social and Occupational Information:

Living situation:
- ☐ Assisted living
- ☐ House, condo, or apartment
- ☐ Nursing care facility
- ☐ Retirement/indep't living
- ☐ Shelter
- ☐ Other: _____

Marital status:
- ☐ Divorced
- ☐ Married
- ☐ Separated
- ☐ Single
- ☐ Widowed

Who lives with you at home: (check all that apply)
- ☐ Alone
- ☐ Child(ren)
- ☐ Friends
- ☐ Grandchild(ren)
- ☐ Parent(s)
- ☐ Sibling(s)
- ☐ Spouse

Home safety issues: check if

- ☐ You have concerns about safety in your home
- ☐ You are (or have been) in an abusive relationship
- ☐ Other _____

Tobacco:
- ☐ Never smoked
- ☐ Current smoker:

Packs per day _____
- ☐ Former smoker:

Stop date: _____
- ☐ Smokeless tobacco

Alcohol:
- ☐ Never used
- ☐ Current user:

Amount: _____
- ☐ Former user:

Stop date: _____

Drug use:
- ☐ Never used
- ☐ Current user:

Type/How often?_____
- ☐ Former user:

Stop date: _____

Check if:

- ☐ You have tried unsuccessfully to quit smoking
- ☐ You have ever been told (or you know) you have a problem with alcohol
- ☐ You have ever been told (or you know) you have a problem with drug use (including prescription medications)

Occupation:

- ☐ Current occupation: _____
- ☐ Retired date: _____
- ☐ Unemployed or laid off date: _____
- ☐ Disabled date: _____

Check if:
- ☐ You are involved in a lawsuit
- ☐ This visit is related to a disability
- ☐ This visit is related to a work injury
- ☐ This visit is related to an auto accident

Please provide details (including attorney address and any claim information) in this space, if applicable.

_____

_____

_____

_____

Patient Name _____ DOB_____

Your Past Medical History and Ongoing Medical Conditions

(Check all that apply)

- ☐ Arthritis
- ☐ Bleeding disorder
- ☐ Cancer
  (state type) _____
- ☐ Dementia
- ☐ Diabetes
- ☐ Headache
- ☐ Head injury
- ☐ Heart disease
- ☐ High cholesterol
- ☐ Hypertension (high blood pressure)
- ☐ Irregular heartbeat
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Multiple Sclerosis (MS)
- ☐ Seizures
- ☐ Stroke

Please list other conditions or illnesses if they are not shown above:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Hospitalizations

reason	when	where

For additional space, use reverse side of this page.

Surgical Procedures

procedure	when

For additional space, use reverse side of this page.

Medical Conditions in Your Family Members

Check all boxes that apply	mother	M Gr mother	M Gr father	father	P Gr mother	P Gr father	brother	sister	other
Alive (A) or Deceased (D)									
Age									
Arthritis _____									
Bleeding disorder _____									
Cancer (type:_____)									
Dementia _____									
Diabetes _____									
Heart Disease _____									
High Cholesterol									
Hypertension (high blood pressure)									
Migraines _____									
Multiple Sclerosis _____									
Seizures									
Stroke									
Other _____									
Other _____									
Other _____									

Patient Name _____ DOB_____

Medication List

Please list all medications you are currently taking.

- Include over-the-counter medications, dietary supplements, etc.
- Attach extra page if needed

	NAME	DOSE	FREQUENCY	REASON	SINCE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

Please list below any medications you have **STOPPED TAKING** within the last two years

	NAME	DOSE	FREQUENCY	REASON	SINCE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

REVIEW OF SYSTEMS

PATIENT NAME (PRINT) _____ DOB _____

Please check Yes below for each that applies.

Constitutional

Yes

- ☐ Any chance of pregnancy
- ☐ Excessive daytime sleepiness
- ☐ Fatigue
- ☐ Fevers
- ☐ Implants/Metal (pacemaker, pump, stent, shunt, aneurysm/heart clip, etc.)
- ☐ Low energy
- ☐ Nicotine Patch
- ☐ Trouble getting to sleep
- ☐ Trouble staying asleep
- ☐ Weight gain
- ☐ Weight loss

Eyes

Yes

- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision

Ears, Nose, Mouth, and Throat

Yes

- ☐ Loss of sense of smell
- ☐ Hearing loss
- ☐ Ringing in your ears

Cardiovascular and Respiratory

Yes

- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath

Gastrointestinal

Yes

- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Bladder & Sexual Function (Genitourinary)

Yes

- ☐ Discomfort and burning
- ☐ Loss of bladder control
- ☐ Loss of desire for sex
- ☐ Menopause (women)
- ☐ Trouble with erection (men)
- ☐ Urgency to urinate

Skin

Yes

- ☐ Change in hair or nails
- ☐ Change in skin color
- ☐ Itching
- ☐ Rash

Neurological

Yes

- ☐ Confusion
- ☐ Falling down
- ☐ Headaches
- ☐ Lack of Coordination
- ☐ Involuntary movements or jerking
- ☐ Lightheaded or dizzy
- ☐ Loss of consciousness/fainting/passing out
- ☐ Numbness
- ☐ Seizure or convulsion
- ☐ Spinning or vertigo
- ☐ Tingling
- ☐ Tremor
- ☐ Trouble speaking
- ☐ Trouble walking
- ☐ Weakness
- ☐ Trouble swallowing

Musculoskeletal

Yes

- ☐ Back pain
- ☐ Joint pain or swelling
- ☐ Muscle pain or cramps
- ☐ Neck pain

Endocrine

Yes

- ☐ Heat or cold intolerance
- ☐ Increased thirst
- ☐ Loss of hair

Memory, Thinking, Mood, Psychiatric

Yes

- ☐ Anxiety
- ☐ Depressed mood
- ☐ Hallucinations (seeing or hearing things)
- ☐ Memory loss

Hematologic (blood) and lymphatic

Yes

- ☐ Anemia
- ☐ Easy bruising or bleeding
- ☐ Slow to heal after cuts

Allergic and Immune

Yes

- ☐ Allergic reaction to medicine or x-ray dye