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 Neurosurgery

Health History Form

PATIENT NAME _____ **TODAY'S DATE** _____

SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____ **AGE** _____ **PHYSICIAN YOU ARE SCHEDULED TO SEE** _____

ADDRESS _____ **APPOINTMENT DATE** _____

CITY _____ **STATE** _____ **ZIP** _____

HOME TELEPHONE # _____

WORK TELEPHONE # _____

CELLULAR TELEPHONE # _____

❑ **MALE** ❑ **RIGHT HANDED**
❑ **FEMALE** ❑ **LEFT HANDED**

REFERRING PHYSICIAN

NAME _____

CITY/STATE _____

PRIMARY PHYSICIAN

NAME _____

CITY/STATE _____

HISTORY OF ILLNESS / REASON FOR OFFICE VISIT

DESCRIBE THE SYMPTOMS YOU ARE EXPERIENCING _____

HOW DID YOUR SYMPTOMS BEGIN? _____

THE SYMPTOMS STARTED ON (GIVE SPECIFIC DATE, IF KNOWN) _____

SINCE YOUR SYMPTOMS BEGAN, THEY HAVE GOTTEN: ❑ **BETTER** ❑ **WORSE** ❑ **NO CHANGE**

NAME ANY OTHER PHYSICIANS WHO HAVE TREATED YOU FOR THIS PROBLEM

PHYSICIAN'S NAME	TYPE OF PHYSICIAN	MONTH/YEAR
1)		
2)		
3)		

HAVE YOU HAD <u>ANY</u> OF THE FOLLOWING TREATMENT(S) FOR THIS ILLNESS OR INJURY?
(CHECK ALL THAT APPLY)

❑ **NONE**
❑ **TRACTION**
❑ **ICE**
❑ **ULTRASOUND**
❑ **PAIN MANAGEMENT PHYSICIAN**
❑ **MEDICATION**

❑ **PHYSICAL THERAPY**
WHEN (MONTH/YEAR) _____
WHERE _____

❑ **HOT PACKS**

❑ **EPIDURAL STEROID INJECTION**
DATE _____

❑ **CHIROPRACTIC MANIPULATION**

❑ **ELECTRICAL STIMULATION**

WHAT MEDICATION HAVE OR ARE YOU NOW TAKING FOR THIS CONDITION? _____

05/099-40-2.0-7.7.11

Patient Name _____ DOB_____

DIAGNOSTIC TESTS

HAVE YOU HAD ANY OF THE FOLLOWING DIAGNOSTIC TESTS FOR THIS ILLNESS OR INJURY?

INDICATE WHEN AND WHERE TESTS WERE DONE

	MONTH	YEAR	WHERE
❑ PLAIN SPINE X-RAYS			
❑ MRI SCAN			
❑ CT SCAN			
❑ MYELOGRAM/CT SCAN			
❑ EMG/NERVE CONDUCTION			
❑ BONE SCAN			
❑ OTHER			

MEDICAL HISTORY OF PATIENT

HAVE YOU EVER BEEN DIAGNOSED WITH?

❑ **DIABETES**
CONTROLLED BY:
❑ INSULIN ❑ DIET ❑ ORAL AGENTS

❑ **ACUTE INFECTION**
❑ **REFLUX DISEASE (GERD)**
❑ **CONGESTIVE HEART FAILURE**
❑ **HISTORY OF HEART ATTACK OR HEART DISEASE**
IF YES, CARDIOLOGIST NAME _____ PHONE _____ ADDRESS _____

❑ **HYPERTENSION**
❑ **HEART DISEASE**
❑ **STROKE**
❑ **TUBERCULOSIS**
❑ **EMPHYSEMA/COPD**
❑ **VENEREAL DISEASE**
❑ **CANCER** (TYPE & TREATMENT) _____

❑ **BLOOD CLOTS**
❑ **GOUT**
❑ **HEART ATTACK** (MI)
❑ **SEIZURES/CONVULSIONS**
❑ **DEPRESSION**
❑ **HIV/AIDS**
❑ **HEREDITARY DEFECTS**

❑ **ASTHMA**
❑ **ANGINA** (CHEST PAIN)
❑ **THYROID PROBLEMS**
❑ **ANXIETY**
❑ **ARTHRITIS**
❑ **BLEEDING TENDENCY**

❑ **OTHER** _____

SURGICAL HISTORY

LIST ALL TYPES OF SURGERY AND YEAR YOU HAD THE SURGERY

_____ _____
_____ _____
_____ _____

MEDICATION HISTORY

LIST <u>ALL</u> YOUR MEDICATION(S) (PRESCRIPTION, OVER-THE-COUNTER, HERBAL)

NAME	AMOUNT	NUMBER PER DAY	NAME	AMOUNT	NUMBER PER DAY

DO YOU TAKE BLOOD THINNERS? ❑ **ASPRIN** ❑ **COUMADIN** ❑ **PLAVIX** ❑ **OTHER**

DO YOU HAVE ANY ALLERGIES?
❑ **NO KNOWN** ❑ **PENICILLIN** ❑ **SULFA** ❑ **DEMEROL** ❑ **MORPHINE**
❑ **LATEX** ❑ **CONTRAST DYE** ❑ **IODINE** ❑ **TAPE** ❑ **SHELLFISH**
❑ **OTHER** _____

Patient Name _____ DOB_____

HAVE YOU BEEN TREATED FOR BLOOD CLOTS? ❑ YES ❑ NO
HAVE YOU BEEN TREATED FOR EXCESSIVE BLEEDING? ❑ YES ❑ NO
HAVE YOU EVER HAD A BLOOD TRANSFUSION? ❑ YES ❑ NO
IS THERE ANY REASON YOU CANNOT RECEIVE A BLOOD TRANSFUSION? ❑ YES ❑ NO
IF YES, EXPLAIN_____

HAVE YOU EVER BEEN SERIOUSLY INJURED? ❑ YES ❑ NO INJURY DATE _____ / _____ / _____
IF YES, EXPLAIN_____

HAVE YOU BEEN HOSPITALIZED IN THE PAST YEAR? ❑ YES ❑ NO
IF YES, EXPLAIN_____

Have you ever had an infection called MRSA? ❑ YES ❑ NO
IF YES, WAS IT TREATED WITH ANTIBIOTICS?_____

FAMILY MEDICAL HISTORY

HAVE YOUR PARENTS OR SIBLINGS (BROTHERS/SISTERS) **EVER BEEN DIAGNOSED WITH?**

❑ **HEART DISEASE** ❑ **DIABETES** ❑ **STROKE** ❑ **CANCER**
❑ **KIDNEY DISEASE** ❑ **DEPRESSION** ❑ **HIGH BLOOD PRESSURE** ❑ **BRAIN TUMOR**
❑ **ANEURYSM** ❑ **LUNG PROBLEMS** ❑ **MULTIPLE SCLEROSIS** ❑ **PARKINSON'S DISEASE**
❑ **ALZHEIMER'S/MEMORY PROBLEMS** ❑ **OTHER** _____

MOTHER: ❑ **LIVING** ❑ **DECEASED** **AGE** _____ **CAUSE OF DEATH**_____
FATHER: ❑ **LIVING** ❑ **DECEASED** **AGE** _____ **CAUSE OF DEATH**_____
SIBLING(S): **# ALIVE** _____ **# DECEASED** _____ **AGE(S)**_____ **CAUSE OF DEATH**_____

SOCIAL HISTORY

MARITAL STATUS: ❑ **SINGLE** ❑ **MARRIED** ❑ **SEPARATED** ❑ **DIVORCED** ❑ **WIDOWED**
DO YOU LIVE ALONE? ❑ **YES** ❑ **NO**
DO YOU HAVE ANY CHILDREN? ❑ **YES** ❑ **NO**
IF YES, LIST THE AGE(S) AND IF THEY LIVE AT YOUR HOME_____

DO YOU NOW USE ANY TOBACCO PRODUCTS? ❑ **YES** ❑ **NO**
IF YES, SPECIFY ❑ CIGARETTES ❑ SNUFF TOBACCO ❑ CIGARS ❑ PIPE
HOW MUCH /DAY _____ FOR HOW MANY YEARS? _____

DID YOU USE ANY TOBACCO PRODUCTS IN THE PAST? ❑ **YES** ❑ **NO**
IF YES, FOR HOW LONG _____ HOW MUCH /DAY _____ WHEN DID YOU QUIT?_____

DO YOU DRINK ALCOHOL? ❑ **YES** ❑ **NEVER** ❑ **NOT CURRENTLY, BUT USED TO DRINK _____ DRINKS A WEEK**
IF YES, SPECIFY ❑ BEER ❑ WINE ❑ LIQUOR AMOUNT PER WEEK _____
FOR HOW MANY YEARS? _____ WHEN DID YOU QUIT?_____

DO YOU USE ANY RECREATIONAL DRUGS? ❑ **YES** ❑ **NO**
IF YES, SPECIFY ❑ MARIJUANA ❑ COCAINE/CRACK ❑ SPEED ❑ HALLUCINOGENS ❑ NARCOTICS
FOR HOW MANY YEARS? _____ WHEN DID YOU QUIT?_____ DATE LAST USED_____

Patient Name _____ DOB_____

WORK HISTORY

HIGHEST LEVEL OF EDUCATION: ❑ GRADE SCHOOL ❑ HIGH SCHOOL ❑ COLLEGE ❑ POST GRADUATE

WORK STATUS: ❑ EMPLOYED ❑ UNEMPLOYED ❑ DISABLED ❑ RETIRED

EMPLOYER _____ **LENGTH OF EMPLOYMENT** _____

JOB TITLE _____ **HOW LONG HAVE YOU PERFORMED THIS JOB?** _____

DO YOU WORK OUTSIDE THE HOME? ❑ YES ❑ NO

IF YES, ARE YOU CURRENTLY WORKING WITH THESE SYMPTOMS? ❑ YES ❑ NO

IF NO, WHEN DID YOU STOP WORKING? _____

DID A PHYSICIAN PLACE YOU OFF WORK? ❑ YES ❑ NO

DOES YOUR JOB REQUIRE YOU TO PERFORM THE FOLLOWING ACTIVITIES?

❑ LIFT ❑ SIT ❑ USE A COMPUTER

❑ BEND ❑ STAND ❑ LIFT OR REACH OVER HEAD

DOES YOUR JOB REQUIRE HEAVY LIFTING? ❑ YES ❑ NO

IF YES, WHAT IS THE MAXIMUM WEIGHT? ____LBS. ____/HR., ____/DAY

SIGN HERE

SIGNATURE OF PATIENT: _____

SIGNATURE OF PERSON FILLING OUT FORM: _____
(IF OTHER THAN PATIENT)

OFFICE USE ONLY:

REVIEWED BY _____ DATE _____

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, stimulator)
- ☐ 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

- SPINE QUESTIONNAIRE -

List ALL symptoms for why you are here (Reason for Visit): _____ Pain _____Numbness/Tingling _____ Muscle Weakness

OTHER _____

How did the symptoms BEGIN?

_____ Spontaneously with no known cause _____As a result of an AUTOMOBILE accident – **Date of Auto Accident**: ____/____/____

_____As a result of an injury at WORK – **Date of Injury**: ____/____/_____ _____As a result of an injury outside of work

My pain is located in my: _____Neck _____ Low back _____Mid-Back Other: _____

Rate your pain: Use this PAIN SCALE of *0 to 10* (*0*=NO PAIN AND *10*=WORST POSSIBLE PAIN) for each affected area:

Neck _____ /10 Low Back _____/10 Mid-Back _____/10 Other affected areas: _____/10

If you have NECK and/or ARM pain:

What percentage of the pain is in your NECK? _____%

What percentage of the pain is in your ARM(s) + _____%

Total Arm/Neck Pain: 100 % (should be 100%)

If you have BACK and/or LEG pain:

What percentage of the pain is in your BACK? _____%

What percentage of the pain is in your LEG(s) + _____%

Total Back/Leg Pain: 100 % (should be 100%)

The PAIN is: _____Constant _____ Intermittent

The PAIN is described as: _____Sharp/Stabbing _____Dull/Aching _____Burning _____Throbbing

The symptoms *IMPROVE* with: _____ Standing _____Walking _____Sitting _____Laying Down

The symptoms *GET WORSE* with: _____ Standing _____Walking _____Sitting _____Laying Down _____Bending

_____Bowel Movements _____Sneezing _____General Activity

Since your condition started, have you experienced any bladder dysfunction? _____Yes _____No

How long can you stand with NO or MINIMAL PAIN? _____ Minutes _____No problem standing for long periods of time.

What distance can your walk with *NO or MINIMAL PAIN*? _____ up to 1 block _____2-3 blocks _____ 6 blocks _____No Limit

Do you need SUPPORT to help you walk? _____YES _____NO If yes, specify:

_____ Use a WHEELCHAIR _____ Use A WALKER _____ Uses a CANE _____Must rely on some PERSON or FURNITURE for support to walk

Do you wear a NECK or BACK brace? If yes, _____Neck Brace _____Back Brace

How long have you worn the brace? ___Days _____Weeks _____Months _____Years

Please check mark the pictures with all symptoms that apply

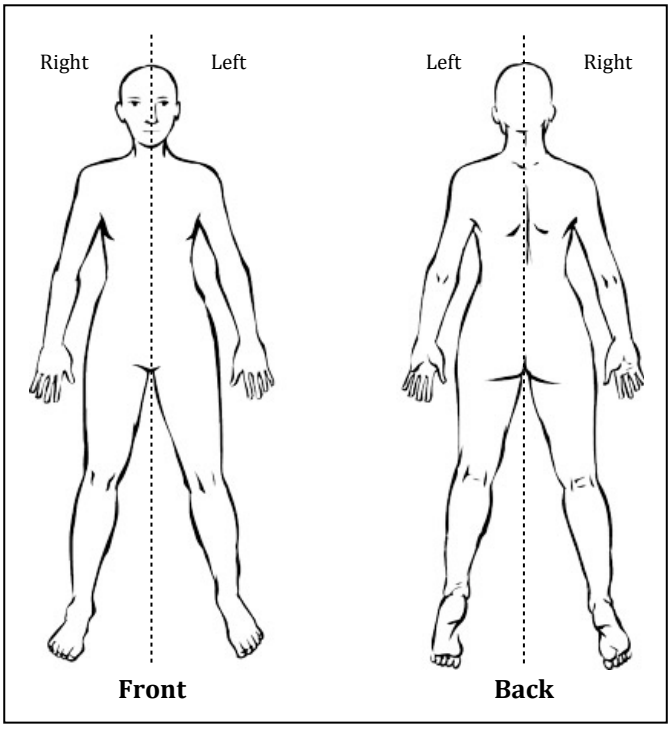
by using the following letters on the picture:

P = Pain

N = Numbness/Tingling

W = Weakness

R = Radiates *(moves from main are into other areas of the body)*



RIVERHILLS NEUROSCIENCE

Medication Treatment Agreement

Patient's Name: _____

Patient's DOB: _____

The goal of medication treatment is to reduce pain, increase ability to function/work, and improve quality of life.

I recognize that I the patient or the person, of whom I am legal guardian, may be treated with potent medications, which are considered controlled substances by local, state and federal agencies. Controlled substances are regulated by the Federal Government to prevent abuse and overuse. While patients are expected to use medications correctly, Riverhills also feels obligated to closely monitor medication usage.

I understand that possible complications of medication therapy includes addiction, chemical dependence, constipation, which could be severe enough to require medical attention, difficulty with urination, drowsiness or reduced mental alertness, nausea, itching, depressed respirations, (and an overdose can cause respiratory arrest and death) reduced sexual dysfunction, and other complications which may be discussed with me by my physician. I understand that the use of pain medication could possibly impair my ability to drive a motor vehicle or use machinery. If I experience any side effects that impair my ability to operate machinery or a motor vehicle, I agree that I will not do so and will report this to my physician.

I understand that if I take more medications than what is prescribed, a dangerous situation could result, such as coma, organ damage, respiratory arrest or even death. I understand that if I run out of my medications too soon, or if my medication is stopped suddenly that I could have medication withdrawal symptoms, which can be very uncomfortable and dangerous.

I therefore agree to follow the conditions listed below:
(INITIALS REQUIRED AFTER EACH STATEMENT)

* I am responsible for my controlled substance medications. I am responsible for taking the medication in the dose prescribed and for monitoring the amount of medication left. I understand that Schedule II prescriptions (OxyContin, Percocet, etc.) will be written only during an office visit. By law, Schedule II prescriptions cannot be mailed or called in. _____ initials

* I may not request nor accept controlled substance medications from any other physician or individual (for the condition I am being treated) while I am receiving such medications from Riverhills Neuroscience. _____ initials

RIVERHILLS NEUROSCIENCE

* I understand that if I run out of controlled substance medication sooner than prescribed, I will not be given a refill until the scheduled time, and that it will be my responsibility to seek emergency care. _____ initials

* I agree to comply with regularly scheduled office visits. _____ initials

* I agree not to take or ingest any illegal substances and agree to refrain from using alcohol. _____ initials

* I understand that the physician is not obligated to replace prescriptions that are lost or stolen. _____ initials

* I understand that I may be selected for a random drug test to verify the dosage prescribed medication in my system and/or for any type of illicit drug. If an illicit drug is positive in the screening, I may be dismissed from Riverhills Neuroscience. I am responsible for the payment coverage of this testing. _____ initials

* I understand that if I violate any of the above conditions, my relationship with Riverhills Neuroscience may be terminated. It will be my responsibility to seek care elsewhere. _____ initials

Please note:

- A 24-hour advance notice is required for refills.
- Refill requests must be phoned in during office hours of 9:00 a.m. to 4:30 p.m. Monday through Friday.
- Refill requests are not permitted during nights, holidays or weekends.
- When permitted, refills will be telephoned to your pharmacy, so please have your pharmacy telephone number available when calling RHN.

To further emphasize the importance of communication with your physician RHN feels it is necessary to inform you of the current laws in place to prevent patients from obtaining medications from different physicians.

It can be a serious offense to receive prescriptions from two separate physicians without both of the physician's prior knowledge. It is important for you as the patient to communicate all treatment/prescriptions received from other physicians. A patient does not have to intentionally hide this fact in order to be found in violation of the law. Silence can be considered deception and therefore an offense.

SIGN HERE

Patient Signature: _____ Date: _____

Print Name: _____ DOB: _____

Witness: _____ Date: _____