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 Rheumatology

Health History Form

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

SOCIAL SECURITY NUMBER _____ APPOINTMENT DATE _____

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

ADDRESS _____ _____

CITY _____ STATE _____ ZIP _____ ☐ MALE ☐ RIGHT HANDED

HOME TELEPHONE _____ ☐ FEMALE ☐ LEFT HANDED

WORK TELEPHONE _____

CELLULAR TELEPHONE _____

REFERRING PHYSICIAN:

NAME _____

CITY/STATE _____

PRIMARY PHYSICIAN:

NAME _____

CITY/STATE _____

**List your allergies in this box:

Or check this box if you have no known allergies ☐

HISTORY OF ILLNESS / REASON FOR OFFICE VISIT

DESCRIBE THE SYMPTOMS YOU ARE EXPERIENCING _____

_____

_____

_____

_____

HOW DID YOUR SYMPTOMS BEGIN? _____

_____

_____

_____

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

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

NAME ANY PHYSICIANS WHO HAVE TREATED YOU FOR THIS PROBLEM

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

HAVE YOU HAD ANY TESTS FOR THESE CURRENT PROBLEMS? ☐ X RAY ☐ MRI ☐ OTHER: _____

HAVE YOU HAD ANY OF THE FOLLOWING TREATMENT(S) FOR THIS ILLNESS OR INJURY?

☐ NONE ☐ PHYSICAL THERAPY ☐ CHIROPRACTIC MANIPULATION

WHEN _____ ☐ EPIDURAL STEROID INJECTION

WHERE _____ DATE _____

PAIN MANGEMENT PHYSICIAN _____

MEDICATION YOU HAVE OR ARE TAKING FOR THIS CONDITION _____

_____

OTHER _____

_____

Patient Name_____ DOB _____

YOUR MEDICAL HISTORY AND ONGOING MEDICAL CONCERNS

CHECK ALL THAT APPLY:

- ☐ ARTHRITIS
- ☐ COLITIS
- ☐ MIGRAINES
- ☐ HYPERTENSION
- ☐ STROKE
- ☐ HEADACHE
- ☐ LIVER DISEASE
- ☐ HIGH CHOLESTERAL
- ☐ SEIZURES
- ☐ OTHER: _____
- ☐ KIDNEY DISEASE
- ☐ CANCER (TYPE)_____
- ☐ STOMACH ULCERS
- ☐ DIABETES
- ☐ BLEEDING DISORDER
- ☐ HEART DISEASE
- ☐ PSORIASIS
- ☐ IRREGULAR HEARTBEAT

_____

YOUR SURGICAL HISTORY

PROCEDURE WHEN

1) _____
2) _____
3) _____
4) _____
5) _____

FAMILY MEDICAL HISTORY

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

- ☐ HEART DISEASE
- ☐ KIDNEY DISEASE
- ☐ ANEURYSM
- ☐ COLITIS
- ☐ DIABETES
- ☐ PSORIASIS
- ☐ LUNG PROBLEMS
- ☐ OTHER _____
- ☐ STROKE
- ☐ TUBERCULOSIS
- ☐ ALCOHOLISM
- ☐ CANCER
- ☐ HIGH BLOOD PRESSURE
- ☐ BLEEDING TENDENCY

MOTHER: ☐ LIVING ☐ DECEASED AGE _____ CAUSE OF DEATH _____

FATHER: ☐ LIVING ☐ DECEASED AGE _____ CAUSE OF DEATH _____

SIBLINGS: # 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 CHILDREN? ☐ YES ☐ NO

IF YES, LIST THE AGE(S) AND IF THEY LIVE IN YOUR HOME:

1) _____
2) _____
3) _____
4) _____

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 ☐ NO ☐ NOT CURRENTLY BUT USED TO DRINK _____ DRINKS PER 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

CURRENT OCCUPATION _____

IMMUNIZATION HISTORY

HAVE YOU RECEIVED ANY OF THESE VACCINES? IF YOU ARE UNSURE, PLEASE CHECK WITH YOUR PRIMARY CARE PHYSICIAN. THERE ARE TWO PNEUMONIA VACCINES. IF YOU DO NOT KNOW WHICH ONE YOU RECEIVED, PLEASE INDICATE:

VACCINE	RECEIVED (YES/NO/UNSURE)	APPROXIMATE DATE RECEIVED
PNEUMONIA VACCINE: PREVNAR (PCV-13)		
PNEUMONIA VACCINE: PNEUMOVAX (PPSV-23)		
FLU VACCINE (ONLY NEED YOUR MOST RECENT)		
SHINGLES (ZOSTER) VACCINE		

MEDICATION LIST

PLEASE LIST ALL MEDICATIONS YOU ARE **CURRENTLY TAKING**.

INCLUDE OVER-THE-COUNTER MEDICATIONS, DIETARY SUPPLEMENTS, ETC.

ATTACH EXTRA PAGE IF NEEED

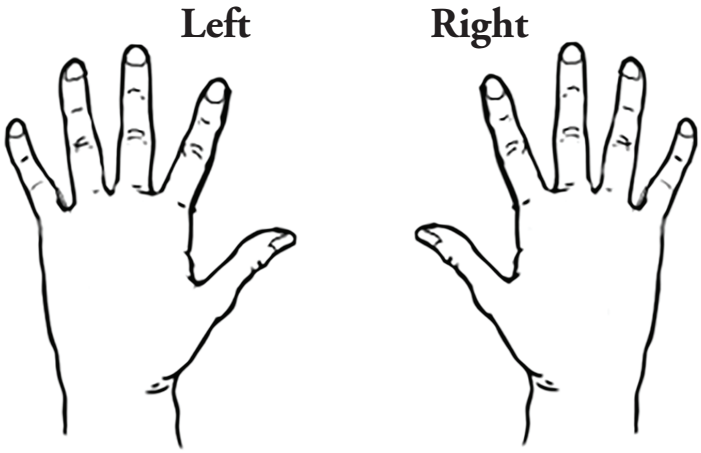
	NAME	DOSE	FREQUENCY	REASON	SINCE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

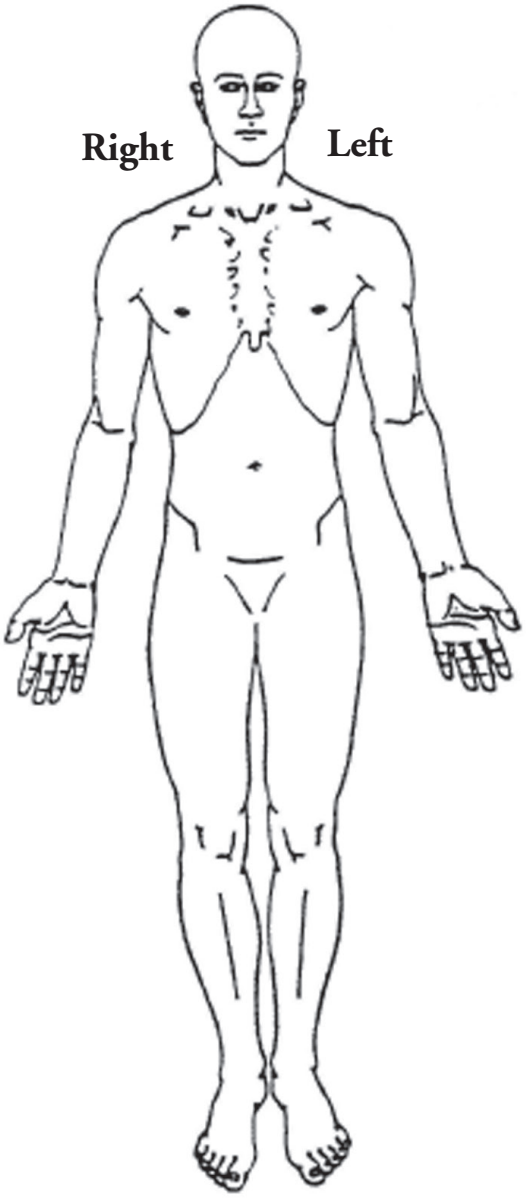
PLEASE LIST BELOW ANY MEDICATIONS YOU HAVE **STOPPED TAKING** WITHIN THE LAST TWO YEARS.

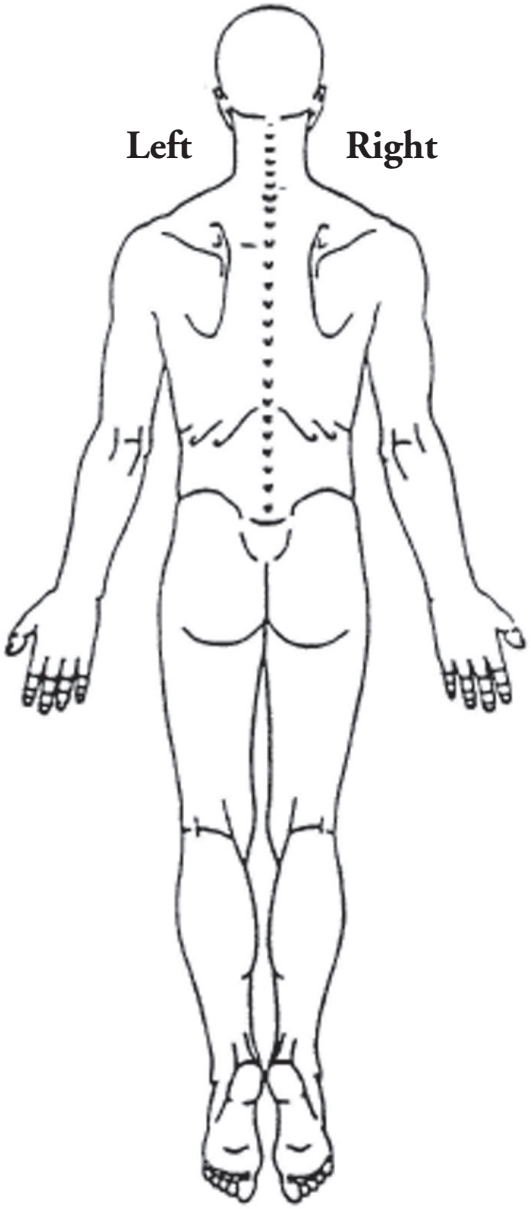
	NAME	DOSE	FREQUENCY	REASON	SINCE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

PAIN MAP

Please shade/draw in where your pain is located on the figures below.







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.)
- ☐ 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

Skin

Yes

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

Neurological

Yes

- ☐ Confusion
- ☐ Falling down
- ☐ Headaches
- ☐ Incoordination
- ☐ 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

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Morning stiffness
  How Long? ____ mins ____ hrs

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