Barrow Department of Neurology
Attention

Barrow Neurological Institute

Please complete the new patient paperwork (pages 5-8, 10-11, 13-16) and bring all of the following items:

- ❑ Photo identification
- ❑ Insurance or medical card
- ❑ Advance Directives
- ❑ Current list of physicians
- ❑ Current medication list with specific dosage
- ❑ Name and/or phone number of primary pharmacy
- ❑ New patient paperwork filled out (Attached)
- ❑ Copies of relevant medical records, if available.

Barrow Department of Neurology
240 W. Thomas Rd.
Phoenix, AZ 85013
Phone: (602) 406-6262
Email: PBSCustomerService@CommonSpirit.org

Language Assistance Services

If you speak English, language assistance services, free of charge, are available to you.
Call 1(800) 443-1986 (TTY: 1(800) 855-7100).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1(800) 443-1986 (TTY: 1(800) 855-7200).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1(800) 443-1986 (TTY: 1(800) 855-7100).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。
請致電 1(800) 443-1986 (TTY: 1(800) 855-7100)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1(800) 443-1986 (TTY: 1(800) 855-7100).

주의: 한국어를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1(800) 443-1986 (TTY: 1(800) 855-7100) 번으로 전화해 주십시오.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1(800) 443-1986 TTY(հեռատիպ)՝ 1(800) 855-7100).

جه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
ِاهم می باشد. با 1(800) 443-1986 (TTY: 1(800) 855-7100 تماس بگیرید.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1(800) 443-1986 (TTY: 1(800) 855-7100) まで、お電話にてご連絡ください。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните
1(800) 443-1986 (телетайп: 1(800) 855-7100).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1(800) 443-1986 (TTY: 1(800) 855-7100) पर कॉल करें।

حوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1(800) 344-6891 (رقم
ف الصم والبكم: 1(800) 558-0017.

ATTENTION: Si vous parlez francais, des services d'aide linguistique vous sont proposes gratuitement. Appelez le
1(800) 443-1986 (ATS: 1(800) 855-7100).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfugung.
Rufnummer: 1(800) 443-1986 (TTY: 1(800) 855-7100).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।
1(800) 443-1986 (TTY: 1(800) 855-8100) 'ਤੇ ਕਾਲ ਕਰੋ।

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para 1(800) 443-1986 (TTY: 1(800) 855-7100).

Barrow Department of Neurology

Helpful Information About Your Provider Visit

Barrow Neurological Institute

1. **Please bring the following items to your appointment:**
   - Photo ID
   - Insurance Card
   - Co-Payment (if any)
   - Current medication list
   - Any records/results requested for your appointment

2. **Arrival Instructions**
   Please plan to arrive 30 minutes prior to the appointment to allow time for parking and completing paperwork.

3. **Parking**
   Park in the 3rd Avenue Parking Garage. Take parking garage elevators to the 2nd floor, exit through the doors to the right and immediately turn left and follow the long hallway to the 240 building elevators around the corner. Use the elevators to access the correct floor for your services. Be sure to bring your parking ticket with you for validation in the clinic.

4. **Obtaining Insurance Prior Authorization and Referrals**
   Many insurance plans require a mandatory prior authorization before a specialist can be seen. Please check with your insurance company to see if this is required on your plan before you come for your appointment. Your provider's office will have a staff member who handles prior authorizations and will be able to answer any of your questions. Authorization must be received prior to your scheduled appointment. Failure to receive prior authorization/referral may result in the need to reschedule your appointment to a later date. Please contact your insurance company for more information.

5. **Telephone Communications**
   Calls to (602) 406-6262 are answered Monday through Friday. Our team is equipped to handle general questions and can direct calls, as appropriate. Additionally, our answering service is here to assist you after hours and on weekends or holidays. If necessary, the on-call provider can be contacted through the answering service. For a life-threatening medical emergency, please call 9-1-1 immediately to activate your local Emergency Medical Service.

6. **Written Communications**
   Please do not fax any time-sensitive communication or urgent medical advice questions to the office.

7. **Electronic Communications**
   Barrow Neurological Institute participates in an electronic patient portal which allows continuous access to your patient information including, but not limited to, upcoming appointments, prior visit summaries, lab and imaging results. Additionally, the portal allows patients to securely communicate with providers directly. Our staff can provide you with an email invitation to set up your portal. Please discuss the procedure for secure electronic communications with your individual doctor or medical assistant.

8. **Appointment Reminder**
   You will receive an automated message via text, email and/or telephone call to remind you of your appointments. Please listen to the message and select one of the following message options:
   - Confirmation of your appointment
   - Cancellation of your appointment and reschedule request
   - General clinic information including address and hours of operation
   - Request to not receive future appointment reminders

   If you do not wish to receive an appointment reminder, please contact the front office staff.

9. **Cancellation of Scheduled Appointments**
   In the event you need to cancel and reschedule an appointment, we ask that you kindly notify us as soon as possible and not later than 24 hours prior to the appointment. We can reschedule you in a timely manner and offer the open slot to another patient. If you are late for your appointment, you may have to be rescheduled. Multiple cancellations with less than 24 hours notice or failure to show will impact our ability to care for you.

10. Test Ordering and Results

Your provider may order diagnostic tests as part of your evaluation and care. Some insurance companies require prior authorization and approval before your test can be scheduled. Your provider will submit orders for these tests and the staff within our clinic will send required documentation to obtain authorization from your insurance company prior to scheduling any test(s).

11. Medical Records

We are unable to share your medical records without a signed release from you. If you need a copy of your medical records from Barrow Neurological Institute, you will need to sign an authorization request. Select records are also available via the patient portal.

You may also pick up a hard copy of your medical records. Note that a fee for this service may be incurred. If you require copies of your medical records, please contact us at (602) 406-8988.

Upon receiving your signed request, a copy of your records will be mailed within two (2) weeks. Please ask our office staff if you have any questions.

In order for us to obtain records from other physician offices, additional forms may need to be completed and signed.

If you need records from a Dignity Health hospital—including lab tests or radiology results—please call the hospital directly and ask to be connected to the Health Information Department.

12. Billing Inquiries

Fees for services are due and payable at the time of your visit, including co-payments, co-insurance and deductibles. Patients are responsible for any services deemed "not-covered" by your plans. If you have questions about a bill you received that was generated from our office and doctor's visit or procedure performed here, please contact Patient Billing Services directly at (602) 406-3860 or toll free at (877) 877-8311, or email PBSCustomerService@CommonSpirit.org.

13. Prompt Pay Discount

If you don't have insurance, you have an option to pay cash at the day of your appointment for a reduced fee. This program is called the Prompt Pay Discount. For more information on this program and to see if you qualify, please contact our office.

14. Patient Satisfaction Survey

We strive to provide an exceptional patient experience. One to four weeks after your visit, please expect to receive a survey via email or mail inquiring about your visit.Your response is confidential and we appreciate your feedback. If there is anything we can do to ensure your experience is exceptional, please share with our staff prior to the end of your visit.

If you have any questions, please speak with your provider or one of our staff members.

We look forward to joining your care team!

Barrow Neurological Institute

PATIENT NAME: _____

MRN: _____

DOB: _____

Demographics

PATIENT INFORMATION

Last Name		First Name	Middle Name
Social Security Number	Date of Birth	☐ Male ☐ Female	Marital Status
Race: ☐ African American (Black) ☐ American Indian/Alaska Native ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander ☐ Hispanic ☐ Other ☐ Two or More Races			
Ethnicity: Hispanic/Latino/Spanish origin ☐ Yes ☐ No		Language	Preferred Language for Health Care Information
Mailing Address		City	State / Zip
Primary Contact Number ☐ Home ☐ Cell ☐ Work ( )	Secondary Contact Number ☐ Home ☐ Cell ☐ Work ( )	Preferred Notify Method ☐ Home ☐ Cell ☐ Work ☐ Other: ( )	
E-Mail Address			
Emergency Contact		Relationship to Patient	Emergency Contact Number:

RESPONSIBLE PARTY'S INFORMATATION (IF OTHER THAN PATIENT) ☐ Self

Last Name	First Name	Middle Name	Relationship to Patient
Social Security Number	Date of Birth	Primary Contact Number ☐ Home ☐ Cell ☐ Work ( )	
Mailing Address		City	State / Zip

FAMILY AND FRIENDS ACCESS (OPTIONAL)

☐ I permit BNI to share my protected health information with the following people:

Full Name:	Full Name:	Full Name:
Relationship to Patient:	Relationship to Patient:	Relationship to Patient:

☐ I do NOT permit BNI to share my protected health information with any individuals aside from myself.

INSURANCE INFORMATION

Primary Insurance Carrier	☐ Workman's Comp	Insurance Billing Address:
Certificate/Policy Number:	Subscriber Full Name:	Subscriber Date of Birth:
Secondary Insurance Carrier		Insurance Billing Address:
Certificate/Policy Number:	Subscriber Full Name:	Subscriber Date of Birth:

Do you have an Advanced Directive in Place (Living Will and/or Medical Durable Power of Attorney)? ☐ Yes ☐ No

FOR OFFICE USE ONLY

Advanced Directives: ☐ Patient refused ☐ Scanned in Chart ☐ Pt Completed AD at Home ☐ Provided AD Informational Brochure ☐ Pt Requested More Information

Barrow Neurological Institute

PATIENT NAME: _____

DOB: _____

DATE: _____

Drug Allergies: _____

New Medication: _____

PCP: _____ **Referring Provider:** _____

Review of Systems:

GENERAL
- ☐ Fevers
- ☐ Chills
- ☐ Sweats
- ☐ Loss Of Appetite
- ☐ Fatigue
- ☐ Weight Gain or Loss
- ☐ Insomnia

Are you a Safe Driver? ☐ Y ☐ N

Have you been in any auto accidents in the past year? ☐ Y ☐ N

EYES
- ☐ Blurred vision
- ☐ Double Vision
- ☐ Vision Loss
- ☐ Eye Pain
- ☐ Light Sensitivity

Other _____

EAR, NOSE AND THROAT
- ☐ Ear Aches
- ☐ Ringing In Your Ears
- ☐ Decreased Hearing
- ☐ Nasal Congestion
- ☐ Difficulty Swallowing

Other _____

CARDIOVASCULAR
- ☐ Chest Pains
- ☐ Palpitations
- ☐ Fainting Spells
- ☐ Shortness of Breath
- ☐ Ankle Swelling

Other _____

RESPIRATORY
- ☐ Coughing
- ☐ Wheezing

GI
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change In Your Bowel Habits
- ☐ Abdominal Pain
- ☐ Bloody or Black Stools

Other _____

GU
- ☐ Pain Upon Urination
- ☐ Blood In Urine
- ☐ Frequent Urination
- ☐ Difficulty Starting To Urinate
- ☐ Frequent Urination At Night
- ☐ Loss Of Bladder Control
- ☐ Loss Of Pregnancy/Miscarriage

Other _____

MUSCULOSKELETAL
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Stiffness
- ☐ Arthritis

Other _____

NEUROLOGICAL
- ☐ Transient Paralysis
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling Sensations
- ☐ Seizures
- ☐ Tremors
- ☐ Headaches
- ☐ Unsteadiness
- ☐ Language Problems

Other _____

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Memory Loss
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Irritability
- ☐ Panic Attacks

Other _____

ENDOCRINE
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Increased Thirst
- ☐ Increased Appetite
- ☐ Large Quantities Of Urine

Other _____

HEME/LYMPHATIC
- ☐ Abnormal Bruising
- ☐ Abnormal Bleeding
- ☐ Enlarged Lymphnodes

Other _____

SKIN
- ☐ Unexplained Rashes
- ☐ Unexplained Itching
- ☐ Suspicious Lesions
- ☐ Alopecia

Have you seen a Dermatologist in past year? ☐ Y ☐ N

ALLERGY/IMMUNOLOGIC
- ☐ Persistent Infections
- ☐ HIV Exposure

OFFICIAL USE ONLY
Height: _____ Weight:_____

B/P: _____/_____ Pulse:_____

Handedness: R / L

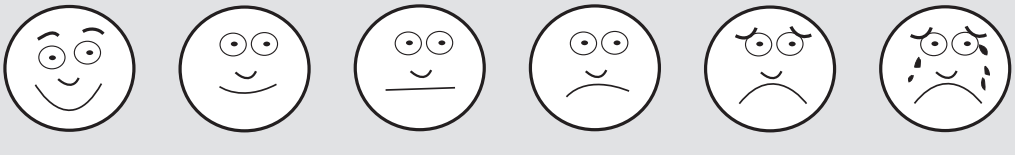
Review of Systems continued:

- ☐ Night Sweats
- ☐ Chronic Cough
- ☐ Coughing up blood
- ☐ Nausea or vomiting more than 7 days
- ☐ Unplanned weight loss
- ☐ Difficulty chewing/swallowing
- ☐ Change in walking ability
- ☐ Change in daily living
- ☐ Do you feel safe at home
- ☐ Fallen in the last 90 days?
- ☐ Any Learning needs or disability?
- ☐ Any thoughts of hurting yourself?

Language preferred/Cultural barrier: _____

Last education level completed:_____

Are you in pain?



0 No hurt

2 Hurts little bit

4 Hurts little more

6 Hurts even more

8 Hurts whole lot

10 Hurts worst

Location of pain: _____

_____

Description of pain: _____

_____

CDC STEADI Fall Risk Self-Screening Tool

We are concerned about our patient's safety while visiting our Dignity Health facility, and want to ensure that we provide the highest level of care.

Please complete the following questions so that the health care provider may better serve you.

Yes	No	
☐ (2)	☐	I have fallen in the past year.
☐ (2)	☐	I use or have been advised to use a cane or walker to get around safely.
☐ (2)	☐	Sometimes I feel unsteady when I am standing or walking.
☐ (1)	☐	I steady myself by holding onto furniture when walking at home.
☐ (1)	☐	I am worried about falling.
☐ (1)	☐	I need to push with my hands to stand up from a chair.
☐ (1)	☐	I have some trouble stepping up onto a curb.
☐ (1)	☐	I often have to rush to the toilet.
☐ (1)	☐	I have lost some feeling in my feet.
☐ (1)	☐	I take medicine that sometimes makes me feel light-headed or more tired than usual.
☐ (1)	☐	I take medicine to help me sleep or improve my mood.
☐ (1)	☐	I often feel sad or depressed.

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool {Rubenstein et al. J Safety Res; 2011:42(6)493-499).

Dignity Health.
St. Joseph's Hospital and Medical Center

CDC STEADI FALL RISK SELF-SCREENING TOOL

SCRN

X-MR-6097 PAGE 1 of 2

Patient Label

Dignity Health Staff Follow Up

For Dignity Health Staff Use Only

- ☐ Patient is at high risk for falls (Score > 4 or "Yes" to any highlighted key question)
- ☐ Patient determined high fall risk by healthcare provider discretion

Fall Prevention/Interventions - check all appropriate answers:

Identification

- ☐ Patient given yellow wristband to wear

Patient Assistance to/from exam room/treatment room or restroom

- ☐ Patient should be escorted with walker
- ☐ Patient should be escorted with wheelchair
- ☐ Patient can be escorted under own power (staff walks alongside patient)

Patient Assistance within exam room/treatment room/area

- ☐ Provide assistance whenever patient is moved from sitting/supine to a standing position and vice versa.
- ☐ Check Recommended Equipment:
  - Gait Belt
  - Other _____
- ☐ Ensure patient is never left unattended or without direct observation in the exam/treatment room while lying on exam or treatment table.
- ☐ If a footboard is utilized for any exam (imaging areas), the technologist will verify that the footboard is secure and locked on the table prior to setting the patient upright.
- ☐ In the event the patient is undergoing a procedure or treatment for an extended period of time, the patient will be taken off the table and seated in a chair with arms.
- ☐ Family/friends at exam/treatment table whenever possible

Education

- ☐ Patient instructed that a staff member should be present each time they walk
- ☐ Patient and/or family provided with CDC STEADI "Check for Safety Brochure" (all patients)
- ☐ While on the exam or treatment table, patients will be instructed not to move without assistance from the outpatient department/clinic staff

Signature:_____ Time:_____ Date:_____

Dignity Health
St. Joseph's Hospital and Medical Center

CDC STEADI FALL RISK SELF-SCREENING TOOL

SCRN

X-MR-6097 PAGE 2 of 2

Patient Label

Barrow Neurological Institute

PATIENT NAME: _____

MRN: _____

DOB: _____

Important Information

Read and initial for each section

_____ **COVID-19 AND ILLNESS SCREENING:** Temperature and symptom screenings will be performed for each patient and visitor upon entry at the clinic. If you are experiencing any symptoms, please contact our office at (602) 406-6262 prior to your visit to determine if your visit should be rescheduled to a later date when you are symptom free.

_____ **VISITOR RESTRICTIONS:** In response to various periods of high infection, we may have restrictions and/or limitations on visitors on the campus. In general, it is best to limit visitors to only one adult.

_____ **CANCELLATIONS, LATE PATIENTS, AND NO SHOWS:** Our goal at Barrow Otolaryngology Clinic is to maximize the time your provider spends with you and minimize your wait time. In order to do so, we have a standardized policy for no shows, cancellations, and late arrivals. Cancellations related to illness do not apply to this policy.

- **Cancellation:** We require 24 hour notice of cancellation for any appointments.
- **Late:** You will be considered late if you arrive 15 minutes after scheduled appointment time.
- **No Show:** If you do not arrive for a scheduled appointment and do not provide the office notice at least 24 hours prior to your appointment, you will be considered a no show.
  - No show #1 - Documented
  - No show #2 - Warning letter mailed out to patient
  - No show #3 - Discharged from office

_____ **FAMILY AND FRIENDS:** You have the option to list up to three (3) individuals that you give permission to know about appointment dates, times, and/or billing information. These individuals may NOT give consent for any in office procedures, immunizations, etc.

_____ **MEDICATION REFILLS:** Please contact your preferred pharmacy to request medication refills. Once the request has been received, refills will be completed within three (3) business days.

_____ **PATIENT PORTAL:** Barrow Neurological Institute participates in an electronic patient portal which allows continuous access to your patient information including, but not limited to, upcoming appointments, prior visit summaries, lab and imaging results. Additionally, the portal allows patients to securely communicate with providers directly. Our staff can provide you with an email invitation to set up your portal.

_____ **FINANCIAL RESPONSIBILITY:** This may include co-payments, co-insurance and services not covered or paid by your insurance carrier. This financial responsibility also applies if your insurance carrier is not contracted

Barrow Neurological Institute

PATIENT NAME: _____

MRN: _____

DOB: _____

with Dignity Health. **It is your responsibility to ensure that all services rendered by Barrow Neurological Institute on your behalf are paid in full within thirty (30) days of the statement date.**

We do not change billing codes once they have been submitted to your insurance company.

It is important that you bring proof of insurance each time you visit the clinic. Failure to do so may result in billing issues for your care. Please make every effort to let us know if your insurance carrier (primary or secondary insurance) or your personal information (home address, employer, and phone number) has changed since your last visit.

_____ **TELECOM AGREEMENT:** You agree that by signing below you consent and request that Dignity Health, its affiliates, and those acting on its/their behalf, may call or text you using an automated telephone dialing system and/or a prerecorded message. The types of calls or texts you may receive include those concerning the patient's care, scheduling, reminders, prescriptions, advertisements or telemarketing messages concerning our benefits and services. Calls can be made to any number you provide or we obtain even if listed on a national or state Do Not Call registry. You understand that consent is not a condition of care.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

_____ **HEALTH INFORMATION EXCHANGE (HIE) STATE PARTICIPATION ACKNOWLEDGEMENT:** I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding Barrow Neurological Institute's participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy. (see pages 11-13)

I have read and understood the above.

_____ _____

Guarantor/Responsible Party or Patient Signature Date

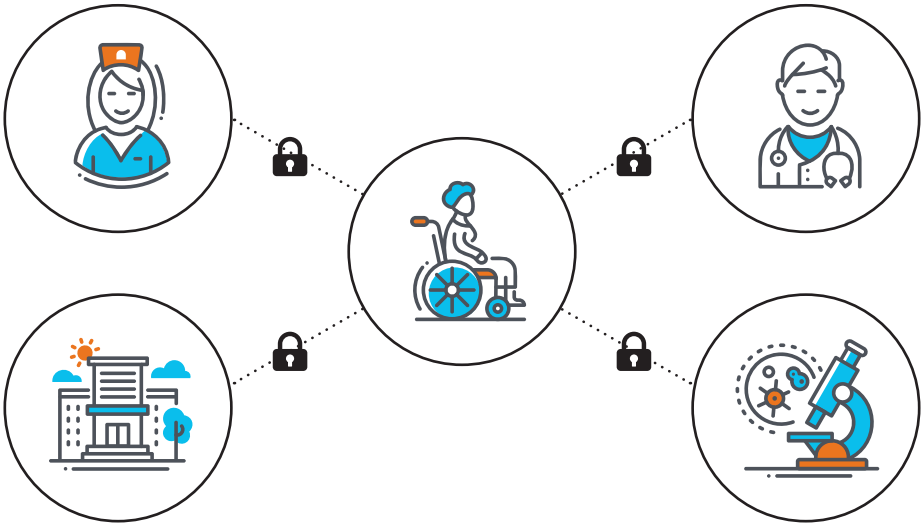
Barrow Department of Neurology

Secure Sharing of Your Health Information

Barrow Neurological Institute

What You Need to Know

Doctors and hospitals can give you better healthcare by sharing your health information electronically. This is very important in emergencies. This sharing is done electronically through Health Current, Arizona's health information exchange (HIE).



Many doctors' offices and hospitals are switching from paper medical records to electronic medical records. During your most recent doctor's visit, you may have noticed your doctor using a laptop or tablet to type in your health information. Now that your health information is stored safely in a computer, it can be shared more easily among your doctors' offices, hospitals, labs, and radiology centers. Your health information is shared securely through the HIE.

Secure sharing of your health information has many benefits:

- Better treatment in an emergency because your doctors will have information about your allergies and your previous problems.
- Prevention of errors and harmful drug interactions.
- Lower overall costs of healthcare by avoiding duplicate tests, procedures and prescriptions.

For details about how your health information will be shared and how it will be protected, please read the Notice of Health Information Practices you received at your doctor's office.

NOTE: If you do not want your health information shared through HIE, please ask your provider for an Opt Out Form. For more information, visit www.healthcurrent.org and click on the Patient Rights button.

Barrow Neurological Institute

PATIENT NAME: _____

MRN: _____

DOB: _____

Joint Notice of Privacy Practices for Health Information (NPP) Acknowledgement Form

Effective April 14, 2003, the law requires that Barrow Neurological Institute give every patient a copy of its Notice of Privacy Practices for Health Information. We will give you a copy at the time of first treatment and if we change our notice, thereafter at the next treatment visit. By signing below, the patient acknowledges receipt of such, or if you are the patient's personal representative, or authorized agent, or involved in patient's medical care, you acknowledge receipt of such. (see pages 17-20)

_____ _____

Acknowledgment Signature Date

_____ _____

If not by patient, print name Relationship to Patient

For Official Use

I provided a copy of the NPP to the patient (or personal representative) but was unable to obtain his or her written acknowledgment of receipt of such for the following reasons:

_____

_____

I have attempted to provide to the patient (or personal representative) a copy of the NPP, but was unable to do so for the following reasons:

_____

_____

Signature of Barrow Neurological Institute Representative: _____Date: _____

Print Name: _____ Department: _____

Barrow Department of Neurology

Medical History Form

Barrow Neurological Institute

Patient Name:_____ **Date of Birth:**_____

Age:_____ ☐ Right Handed ☐ Left Handed

Reason for visit: _____

Symptoms: _____

When does/did it occur? _____

Describe severity_____

Made better by: _____

Made worse by: _____

Past Medical History and Dates Diagnosed:

☐ Diabetes _____

☐ High Blood Pressure _____

☐ Heart Attack _____

☐ Stroke _____

☐ Seizures _____

☐ Liver Disease _____

☐ Asthma _____

☐ Lung Disease _____

☐ Kidney Disease _____

☐ Cancer/Tumors _____

☐ HIV/AIDS _____

☐ Surgery _____

☐ Trauma _____

☐ Thyroid problems _____

☐ Ulcers _____

☐ Back problems _____

☐ Heart Valve problems _____

☐ Hyperlipidemia _____

☐ Other Medical Illnesses _____

Past Surgical History and Dates of Surgeries:

Date: _____ Type: _____

Date: _____ Type: _____

Artificial Parts:

☐ Implants ☐ DBS/VNS

☐ Limb prosthesis ☐ Heart valve

☐ Pacemaker/AICD ☐ Other: _____

Family History:

☐ Diabetes	☐ Mother	☐ Father	☐ Sibling
☐ High blood pressure	☐ Mother	☐ Father	☐ Sibling
☐ Heart Attack	☐ Mother	☐ Father	☐ Sibling
☐ Stroke	☐ Mother	☐ Father	☐ Sibling
☐ Seizures	☐ Mother	☐ Father	☐ Sibling
☐ Multiple Sclerosis	☐ Mother	☐ Father	☐ Sibling
☐ Parkinson Disease	☐ Mother	☐ Father	☐ Sibling
☐ Cancer	☐ Mother	☐ Father	☐ Sibling

☐ Other: _____

Father died age _____ of: _____

Mother died age _____ of: _____

Brother died age _____ of: _____

Sister died age _____ of: _____

_____ died age _____ of: _____

_____ died age _____ of: _____

Social History:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Spouse: Age:_____ Health Status: _____

Children: ☐ Male ☐ Female Age:_____ Health Status: _____

☐ Male ☐ Female Age:_____ Health Status: _____

☐ Male ☐ Female Age:_____ Health Status: _____

Lost pregnancies/miscarriages: _____ Last menstrual period: _____

Occupation: _____ Education: _____

Physical Exercise: _____ Stress: _____

Tobacco: ☐ 0 ☐ < 1ppd ☐ 1ppd ☐ > 1ppd Quit:_____ Years:_____

Alcohol: ☐ 0 ☐ 1-5 per week ☐ > 5 per week Quit:_____ Years:_____

Recreational Drug Use: _____

IV Drug Use: _____

HIV high-risk behavior: _____ STD: _____

Drug Allergies:

_____

_____

_____

Medications:

Dose, strength, and frequency (prescribed and over-the-counter)

Name of Medication	Dosage (mg) # of pills	Frequency

Pharmacy Information:

Name of local pharmacy: _____ Phone number: _____

Name of mail order pharmacy: _____ Phone number: _____

Name/specialty/contact information for your other doctors:

Name: _____ Name: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Name: _____ Name: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Name: _____ Name: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____