

PATIENT EDUCATION AND SELF-ASSESSMENT

Why have you come to see the neurologist? _____

The Doctor or Nurse will need to educate you about your condition and/or medication.

- 1. Please indicate if you believe any of the items listed below will interfere with your ability to learn about your medical condition(s) or medication(s).
 - No difficulties
 - I cannot hear well enough to receive verbal information
 - I cannot see well enough to read printed information
 - I do not speak English well
 - I cannot read English well
 - I have trouble remembering things
 - Other, specify _____

- 2. Is there someone needed to interpret for you? Yes No

- 3. How do you prefer to learn?
 - Written instructions
 - Oral instructions
 - Demonstrations

- 4. Are you experiencing pain or have you had pain in the past 6 months? Yes No
If yes, location: _____ rate 0-10 (0=no pain, 10=severe pain) _____

- 5. Have you fallen within the last 6 months? Yes No

- 6. Do you have any dietary restrictions? _____

- 7. Can we leave messages regarding your test results or other medical communication?
 - At your home Yes No telephone # () _____ - _____
 - At work Yes No telephone # () _____ - _____
 - On a cell phone Yes No telephone # () _____ - _____

Patient's signature/Person completing form

Date

Office Use Only

MD/ Designate reviewed this form

Date

No limitations or barriers to learning

See office notes for comments

Name (please print) _____ Date of Birth _____

Information on this page will help your doctor understand your medical problems. Please explain any current or past problems or surgeries in the space below.

MEDICAL AND SURGICAL HISTORY

Hypertension: _____

Eye, ear, nose, throat: _____

High cholesterol, diabetes, thyroid disease: _____

Abnormal heart rhythm, heart attack, angina: _____

Lungs or chest: _____

Esophagus, stomach or intestines: _____

Liver, gall bladder: _____

Kidneys, urinary bladder: _____

Muscles, joints, bones: _____

Skin, breast: _____

Spinal cord, brain: _____

Mental illness: _____

Blood (anemia, abnormal bleeding): _____

FEMALES: vagina, uterus, tubes, ovaries: _____

MALES: prostate, penis, testes: _____

SOCIAL HISTORY

You are: Single Married Divorced Widowed
You are: Alone With Family Other _____

Your occupation _____ Highest level of education _____

Are you disabled? No Yes If yes, why? _____

Smoking habits: Never Past Now How much? _____ pack per day How long? _____

Use of alcohol: None Occasional Most days

MEDICATION ALLERGIES _____

PLEASE LIST MEDICATIONS ON THE SEPARATE MEDICATION PAGE

FAMILY HISTORY

	Age(s) or Age(s) at Death	Medical Problems	Cause of Death
Children	_____	_____	_____
Sister(s):	_____	_____	_____
Brother(s):	_____	_____	_____
Mother:	_____	_____	_____
Father:	_____	_____	_____

PATIENT SIGNATURE _____ **DATE** _____

Name: _____ Date of Birth: _____

Information on this form will help your doctor understand your medical problems. Please mark whether the symptoms listed are currently present or absent.

REVIEW OF SYSTEMS (SYMPTOMS)					
Currently	Present	Absent	Currently	Present	Absent
1. Constitutional			8. Musculoskeletal		
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Aches	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Joint Aches	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>			
2. Eyes			9. Integument (Breast)		
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Breast Lump	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	10. Psychiatric		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
			Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
			Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
3. Ears, Nose, Mouth, Throat			11. Endocrine		
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Ringing of Ears	<input type="checkbox"/>	<input type="checkbox"/>	Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Congestion	<input type="checkbox"/>	<input type="checkbox"/>			
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	12. Hematologic/Lymphatic		
			Easy Bleeding or		
4. Cardiac			Bruisability	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Calf Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Lymph Node Swelling		
(Heart racing or fluttering)	<input type="checkbox"/>	<input type="checkbox"/>	Or Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
5. Respiratory			13. Allergic/Immunologic		
Shortness of Breath			Swelling of Mouth, Skin		
At Rest	<input type="checkbox"/>	<input type="checkbox"/>	or Oral Cavity	<input type="checkbox"/>	<input type="checkbox"/>
On Exertion	<input type="checkbox"/>	<input type="checkbox"/>	Rash w/Food Ingestion	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>			
			14. Neurologic		
6. Gastrointestinal			Headache	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Understanding	<input type="checkbox"/>	<input type="checkbox"/>
Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Speaking	<input type="checkbox"/>	<input type="checkbox"/>
Dark, Tarry Stools	<input type="checkbox"/>	<input type="checkbox"/>	Slurred Speech	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
			Difficulty Walking	<input type="checkbox"/>	<input type="checkbox"/>
7. Genitourinary			Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Slowing of Thought		
Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	or Cognition	<input type="checkbox"/>	<input type="checkbox"/>
(Loss of Control)					
Burning on Urination	<input type="checkbox"/>	<input type="checkbox"/>	15. Localized Pain	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			

COMMENTS: _____

Patient's Signature: _____ Date: _____

UNIVERSITY NEUROLOGISTS

IF THERE IS ANY ADDITIONAL PHYSICIAN THAT WOULD LIKE A COPY OF THE REPORT FROM YOUR VISIT WITH US, PLEASE COMPLETE THE INFORMATION BELOW.

_____ Please check if this is the referring physician.

PHYSICIAN'S NAME: _____

ADDRESS: _____

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

PHONE NUMBER: _____

FAX NUMBER: _____

PHYSICIAN'S NAME: _____

ADDRESS: _____

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

PHONE NUMBER: _____

FAX NUMBER: _____

Patient Name: _____

Date of Birth: _____

WHAT TO BRING TO YOUR VISIT:

- √ **Copies of medical records and MRI films (actual films or disc) and MRI written report**
- √ **A list of medications, including names and doses**
- √ ***HMO PATIENT: Must bring a referral form or your appointment may be subject to rescheduling***
- √ ***COMMERCIAL INSURANCE PATIENTS: Co-payment or deductibles are due at the time of service (according to your insurance plan and their contract with Rush.***
- √ ***PUBLIC AID PATIENTS: Must bring a current public aid card and be prepared to pay the deductible at the visit***
- √ **INSURANCE CARD (S) AND PICTURE ID**
- √ **Patient Self Assessment Form, Medical History and Financial Policy completed and signed**
- √ **Name and address of any additional doctor who should receive a copy of your report**
- √ **If the patient does not speak English, please have a family member or friend accompany the patient. A certified Rush interpreter will also be required. Please notify us at least 48 hours in advance so our office can make the necessary arrangements.**