Fernando Miranda MD **Neurology Patient Information**

Today's Date: _____

First Name: _____ Last: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Primary Care Physician: _____ Referring Provider: _____

Date of Birth: _____ Circle One: Male Female

Emergency Contact (Name, Phone, and Relation): _____

_____

Attorney Name and Phone (only for legal): _____

_____

INSURANCE

Insurance Subscriber/Policy Holder Name: _____

Insurance Name: _____ Social Security # _____

Subscriber Date of Birth: _____

Subscriber ID: _____ Group Policy #: _____

Patient Signature: _____

Printed Name and Relationship if signed by a responsible party other than the Patient:

_____

Adult Summary Form

Name: _____ Age: _____

Date of Birth: _____

Height: _____ Weight: _____

Medical Problem List	Date
Past Surgical History	Date
Hospitalizations	Date
Medication List Dosage Frequency	
Medication Allergies	
Any neurological studies performed? MRI, CT, EEG, EMG? Any Implants?	
Pharmacy Name:	
Address:	
Phone:	

Please check box if you have any of the following:

General	**Endocrinology**	**Neurological**
Y	**Y**	**Y**
☐ Fever	☐ Cold Intolerance	☐ Change of vision (blurry, double)
☐ Night sweats	☐ Excessive sweating	☐ Loss of hearing
☐ Weight changes	☐ Excessive thirst	☐ Facial numbness
Cardiovascular	☐ Heat Intolerance	☐ Facial weakness
☐ Shortness of breath	☐ Hot flashes	☐ Decreased sense of smell or taste
☐ Chest pain	☐ Urinating frequently	☐ Difficulty swallowing
☐ Irregular heartbeat		☐ Slurred speech
Respiratory	**Hematology**	☐ Headache
☐ Chronic cough/coughing blood	☐ Easy bruising	☐ Dizziness
☐ Emphysema	☐ Nose bleeds	☐ Seizures
☐ Bronchitis	☐ Excessive bleeding with previous surgeries	☐ Pain in the arm
☐ Asthma		☐ Pain in the leg
Gastrointestinal	**Dermatology**	☐ Numbness of the arm
☐ Abdominal pain	☐ Rash	☐ Numbness of the leg
☐ Blood in stool	☐ Hives	☐ Weakness in the leg
☐ Constipation	☐ Lumps	
☐ Diarrhea		**Musculoskeletal**
☐ Difficulty swallowing		☐ Neck pain
☐ Heartburn		☐ Loss of arm/leg coordination
☐ Nausea		☐ Back pain
☐ Vomiting		☐ Trouble walking
☐ Constipation		
Psychological		
☐ Depression		
☐ Anxiety		

History:

Any medical problems family members?

Father_____

Mother_____

Siblings_____

Children_____

Occupation: _____

Marital status: □ SINGLE □ MARRIED □ DIVORCED □ WIDOWER

Education: □ GRADE SCHOOL □ MIDDLE SCHOOL □ HIGH SCHOOL □ GED □ COLLEGE

Do you exercise?

Do you currently smoke?

Do you drink alcohol? Illicit drugs?

Signature: _____ Date: _____