Sandia Neurology Intake Form 2019

Please fill out completely and give to front desk staff when finished.

Name of patient _____ Gender M F Date of Birth ____/____/_____

Legal Name _____ Age _____

Primary provider _____ Referring provider _____

Billing address _____ Cell phone _____

City State Zip _____ Work phone _____

Email _____

Occupation _____ Employer _____

Social Security Number _____ Home phone _____

Spouse _____ Spouse phone _____

Emergency Contact _____ Emergency contact Phone _____

Insurance Company _____ Policy number _____ Group number _____

Name of subscriber _____ DOB _____ SS #_____ Phone _____

Employer of subscriber _____ Occupation of subscriber _____

Reason for this appointment _____

Medical History and Intake Form 2019

Date:_____

Name:_____ Date of Birth_____

Referring Provider:_____ Reason for Referral:_____

Primary Care Provider:_____

Name and relationship of person completing this from (if person is not patient) _____

Email _____

Owner of insurance plan _____ Date of Birth _____ Social Sec No _____

symptoms:

Fatigue	Eye pain	Bowel accidents	Need for cane/ walker/ wheelchair	Trouble with walking
Fever	Chest pain	Bladder accidents		Falling
Weight loss	Palpitations	Urgency of urine	Headache/Migraine	Other symptoms:
Weight gain	Fainting	Pregnancy	Memory loss	_____
Accidents	Heart Problems	Impotence	Numbness	_____
Smoking	Shortness of breath	Depression	Tingling	_____
Vision changes	Trouble with sleep	Anxiety	Tremor	_____
Double vision	Snoring	Hallucinations	Seizure	_____
Vision loss	Morning fatigue	Anemia	Weakness	_____

Past Medical Problems

Alzheimers	Dementia	Heart Disease	Operations_____	Other_____
Parkinsons	Migraine	High Blood Pressure	_____	_____
Multiple Sclerosis	Head injuries_____	Anemia	_____	_____
Epilepsy	Neck injuries_____	Osteoporosis	_____	_____
Neuropathy	Tremor	Sleep Apnea	_____	_____
Stroke/TIA	Cancer_____	Fibromyalgia		_____
Toticollis	Thyroid	Asthma		_____
Spasticity	Diabetes			

Social History:

Job:_____	Exercise:_____	Recreational Drugs Y N
Education:_____	Tobacco Y N	Cannibus Y N how often_____
Marital Status:_____	date quit _____date started_____	packs per day _____ecig _____
Number of Children:_____	Alcohol Y N	

Family Health: List known medical conditions for family members:

Mother:_____

Father:_____

Siblings:_____

Grandparents:_____

Other:_____

Drug Allergies:

_____

Current Medications and Supplements taken:

_____

_____

_____

_____

_____