NEUROLOGY
OF MARSHALL COUNTY

Sheri L. Swader, M.D.

Date: _____

Social Security Number: _____ - _____ - _____

Patient Name: _____ _____ - _____ - _____ _____

Last First Middle Initial Date of Birth Age

Mailing Address: _____ **City:** _____ **Zip:** _____

Street Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Patient Employer: _____ **Employer's Phone Number:** _____

□ Male □ Female □ Non Hispanic □ Hispanic Language: _____

Pharmacy: _____ **City:** _____

Email Address: _____

- **SPOUSE'S INFORMATION:**

Name: _____ **Social Security Number:** _____ - _____ - _____

Mailing Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Date of Birth: _____ - _____ - _____ **Employer:** _____

- **RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT) Relation to Patient:** _____

Name: _____ **Social Security Number:** _____ - _____ - _____

Mailing Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Date of Birth: _____ - _____ - _____ **Employer:** _____

- **EMERGENCY CONTACT PERSON: (*Must have phone number different than patient*)**

Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____ **Date of Birth:** _____

- **METHOD OF PAYMENT: □ Cash □ Insurance □ Worker's Comp**

Is your visit related to employment / work-related injury? _____

Referred by: _____ **Family Physician:** _____

PATIENT NAME: _____

- **SOCIAL HISTORY (Please check the appropriate box.)**

Marital Status: □ Married □ Single □ Divorced □ Widowed

Work: □ Part-time □ Full-time □ Retired □ Disabled Occupation: _____

Children: □ Yes □ No

Tobacco Use: □ Present User □ Former User □ Never Used

Do You Drink Alcoholic Beverages: □ Yes □ No If yes, □ Occasional □ Moderate □ Heavy

- **MEDICAL INFORMATION / HISTORY**

Height: ____ ft ____ inches **Weight: _____**

Do you have a history of COVID? □ Yes □ No Have you completed the COVID vaccine series? □ Yes □ No

Do you have a pacemaker or any other device? □ Yes □ No If yes, what type? _____

Are you taking ANY blood thinners? □ Yes □ No If yes, what type? _____

Have you ever had surgery? □ Yes □ No If yes, please list all surgeries: _____

_____

_____

_____

Are you allergic to any medications? □ Yes□ No If yes, please list all medications: _____

_____

_____

- **MEDICAL CONDITIONS** **(Please mark an X beside any conditions you have currently or have previously had.)**

___ AFIB (Atrial Fibrillation)
___ Allergic Rhinitis
___ Allergic Rhinitis
___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Blood Clots
___ Cancer (Type: _____)
___ Chronic Acid Reflux (GERD)
___ Chronic Kidney Disease
___ COPD
___ Coronary Artery Disease
___ Hepatitis (A, B or C)
___ Deep Vein Thrombosis
___ Dementia
___ Depression
___ Diabetes – Type 1
___ Diabetes – Type 2
___ Fibromyalgia
___ Headaches (Type: _____)
___ Heart Attack
___ Heart Disease
___ High Blood Pressure
___ High Cholesterol/Trig
___ Kidney Disease
___ Kidney Stones
___ Liver Disease
___ Neuropathy
___ Osteoarthritis
___ Rheumatoid Arthritis
___ Seasonal Allergies
___ Stroke / TIA
___ Thyroid Disorder
___ Tremor
___ Ulcers
Other: _____
Other: _____
Other: _____
Other: _____
Other: _____
Other: _____

- **FAMILY MEDICAL HISTORY** **(Please mark an X beside any conditions you have currently or have previously had.)**

_____ Unknown / Adopted

Please mark an X in the line if any of your <u>IMMEDIATE FAMILY MEMBERS</u> HAVE A HISTORY OF THESE LISTED CONDITIONS. (Immediate family members include: MOTHER, FATHER, BROTHER, SISTER, GRANDMOTHER, GRANDFATHER AND CHILD.)

_____ Aids/HIV
_____ Blood Clots
_____ Breast Cancer
_____ Colon Cancer
_____ Coronary Artery Disease
_____ Cystic Fibrosis
_____ Dementia
_____ Diabetes
_____ Gout
_____ Headaches
_____ Heart Attack
_____ Heart Disease
_____ High Blood Pressure
_____ High Cholesterol
_____ Huntington's Disease
_____ Kidney Disease
_____ Liver Disease
_____ Lung Cancer
_____ Muscular Dystrophy
_____ Neuropathy
_____ Osteoarthritis
_____ Prostate Cancer
_____ Rheumatoid Arthritis
_____ Seizures
_____ Sickle Cell Anemia
_____ Stroke/TIA
_____ Tremor

Review of Symptoms

(Please make a check mark beside any of the symptoms you have experienced in the LAST 6 MONTHS.)

Constitutional
___Poor General Health Recently
___Recent Weight Change, Loss of Appetite
___Fever, Chills, Profuse Sweating
___Fatigue, Lethargy, Malaise

Eyes
___Recent eye disease, injury or surgery
___Blurred vision, double vision, loss of vision
___Pain in the eyes
___Eye examination within the last year

Ears, Nose, Mouth, Throat
___Hearing loss or ringing in the ears
___Ear pain or discharge
___Chronic or recurring sinus problems
___Chronic or recurring sores in the nose or mouth
___Chronic or recurring dental problems
___Chronic or recurring sore throat

Cardiovascular
___Chest pain
___Rapid or irregular heartbeat, palpitations
___Sudden loss of consciousness, fainting
___Shortness of breath with exertion
___Swelling of the feet, ankles or hands

Respiratory
___Chronic coughing
___Coughing up blood
___Chronic wheezing, asthma
___Chronic shortness of breath

Gastrointestinal
___Recurring nausea and vomiting, vomiting blood
___Abdominal pain
___Chronic or recurring diarrhea or constipation
___Bloody bowel movements
___Jaundice, liver disease

Genitourinary
___Frequent or painful urination
___Blood in the urine
___Urinary incontinence
___Loss of sexual desire or sexual dysfunction
___Irregular or painful menstrual periods

Musculoskeletal
___Joint pain, stiffness or swelling
___Muscle pain, weakness or cramping
___Limitation of motion, difficulty walking
___Chronic neck or back pain
___Chronic foot pain or deformity

Skin and Breasts
___Chronic or recurring rashes or sores
___Suspicious moles or lesions
___Hair loss, change in nails
___Breast pain, breast lump or nipple discharge

Neurologic
___Frequent or recurring headaches
___Dizziness, lightheadedness
___Seizures or convulsions
___Loss of sensation or muscle strength
___Stroke or head injury
___Memory loss, confusion
___Tremor

Psychiatric
___Nervousness or anxiety
___Chronic depression
___Inability to concentrate
___Sleep problems

Endocrine
___Excessive thirst or urination
___Heat or cold intolerance
___Unexplained change in skin pigmentation
___Change in hat or ring size
___Loss of height
___Unexpected bone fractures

Hematologic / Lymphatic
___Recurring nosebleeds, bleeding gums, bruising
___Chronic anemia, recent transfusion
___Swollen lymph nodes
___Recurring infections

Allergic / Immunologic
___Hay fever
___Recurring hives
___History of HIV or AIDS

PATIENT NAME: _____

- **CURRENT MEDICATIONS:** Please list ALL medications you are currently taking and the dosage. Please include all prescription and over the counter medications.

☐ **CHECK HERE IF YOU TAKE NO PRESCRIPTION OR OVER THE COUNTER MEDICATIONS.**

MEDICATION	**DOSAGE (mg, etc.)**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Neurology of Marshall County's Notice of Privacy Practices. By signing below I am only giving acknowledgement that I have received or have had the opportunity to receive the Notice of Privacy Practices.

_____ _____

Patient Name (Printed) Date

Signature: _____

RELEASE OF INFORMATION AUTHORIZATION:

Due to federal privacy guidelines (HIPPA), Neurology of Marshall County is not allowed to divulge information to anyone other than the patient (or guardian of the patient) unless explicit written authorization is given to discuss personal medical information with someone other than you.

I, _____, give Neurology of Marshall County permission to release / discuss personal medical information to include the pickup of prescriptions and / or financial information to:

Name: _____Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Signature of Patient: _____ Date: _____

GUARANTEE OF ACCOUNT: MUST BE 19 YEARS OF AGE TO SIGN

I, the undersigned, directly assign to Neurology of Marshall County all surgical and / or medical benefits, if any, otherwise payable to me for services rendered.

In consideration of services rendered or to be rendered, the undersigned agrees to pay all costs of collection and / or reasonable attorney fees, should the account be turned over to enforce collections of said charges. The undersigned hereby waivers all claims or rights of exemption allowed by the constitution of the state of Alabama or any other state of the United States.

I hereby authorize Neurology of Marshall County to release any information necessary to secure payment of benefits to my account.

Signature: _____ Date: _____

May we leave voicemails on the numbers you've provided? □ Yes □ No

Comments: _____