University of California
San Francisco

Department of Neurology

NEW PATIENT PROFILE
NEUROLOGY

PLEASE ANSWER ALL QUESTIONS AND BRING THE COMPLETED QUESTIONNAIRE TO YOUR EVALUATION APPOINTMENT. THIS WILL HELP US PROVIDE YOU WITH THE BEST SERVICE POSSIBLE. YOUR RESPONSES TO THESE QUESTIONS WILL ASSIST THE DOCTORS IN THEIR EVALUATIONS AND WILL BE FILED IN YOUR CONFIDENTIAL MEDICAL RECORD.

YOUR NAME (First, Middle, Last):______________________________

Birth date:____/____/____ Male_____ Female____ Current marital status: Single____ Married____ Divorced____ Widowed____

Are you currently employed No_____ Yes_____ If yes, specify your primary occupation:______________________________

If you have retired, When? Date/Year__________ Primary occupation:______________________

Why are you seeking an evaluation at this time?______________________________

____

Are there any recent events that have caused you concern? Please specify:

____

____

CURRENT MEDICATIONS

Are you currently taking any medications? No_____ Yes_____
If yes, list all current medications including over the counter medicines, herbal products, etc.

NAME OF MEDICATION	DOSE	REASON FOR TAKING	DATE PRESCRIBED

Are you allergic to any drugs? No_____ Yes_____(If yes, please list the names of all the drugs.)

____

____

Do you have an allergy to iodine or radiologic contrast dye? No_____ Yes_____ If so, what are the symptoms of your reaction?

____

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MEDICAL HISTORY

Have you had any operations or hospitalizations in the past? No_____ Yes_____
If yes, specify Reason for Hospitalization: Specify Date/Year

___

DO YOU HAVE A HISTORY OF THE FOLLOWING ILLNESSES? CHECK CORRECT RESPONSE.

	Yes	No	Not Sure		Yes	No	Not Sure
Arthritis	❑	❑	❑	Loss of Consciousness/Amnesia	❑	❑	❑
Cancer	❑	❑	❑	Meningitis or Encephalitis	❑	❑	❑
Chronic Lung disease	❑	❑	❑	Psychiatric/Psychological Treatment	❑	❑	❑
Depression	❑	❑	❑	Rheumatic fever	❑	❑	❑
Diabetes	❑	❑	❑	Seizure	❑	❑	❑
Epilepsy	❑	❑	❑	Serious Head Injury	❑	❑	❑
Gallstones	❑	❑	❑	Stomach Ulcers	❑	❑	❑
Headache	❑	❑	❑	Stroke	❑	❑	❑
Heart Disease / Attack / Murmur	❑	❑	❑	Syphilis	❑	❑	❑
Hypertension/High blood pressure	❑	❑	❑	Thyroid disease	❑	❑	❑
Kidney disease / Renal Stones	❑	❑	❑	Tuberculosis	❑	❑	❑
Liver disease/Hepatitis	❑	❑	❑	History of Other Medical Problems	❑	❑	❑

If you have answered yes to any of these, please provide details and date of occurrence:

___

___

___

Have you ever had a blood transfusion or received either clotting factor concentrates or platelet transfusions? No_____ Yes_____ Specify Date/Year

___

___

FAMILY HISTORY

Please provide the following information about your family, that is your parents, brothers, sisters and children. Please note if they have any major illness or history of brain or movement disorder. Please state cause of death if known. If you cannot answer the question, please indicate by D/K (don't know). If you have no children or sibling, please mark N/A (not applicable)

	Alive	Age	Major Illness	Deceased	Age	Cause of Death	History Brain or Movement Disorder
Mother							
Father							
Brothers							
Sisters							
Children							
Children							
Children							

If anyone above has a history of movement disorder, please provide details:

____

____

List any other Family Neurological Problems:

____

____

SOCIAL HISTORY

Do you drink alcohol? Yes_____ No_____ I have abstained since__________(date).

If yes, how much on average is your daily intake. Beer:__________ Wine:__________ Liquor:__________

Do you smoke cigarettes? Yes_____ No_____ If yes, average number of packs per day_____ Number of years_____

Have you ever used recreational drugs? Yes_____ No_____

If yes, provide details:

____

How many grades did you complete in school?_____

REVIEW OF SYMPTOMS

Have you experienced problems with any of the following symptoms:

Mental Status	Yes	No	Don't Know
Confusion	❑	❑	❑
Poor memory	❑	❑	❑
Difficulty finding words	❑	❑	❑
Forgetting appointments	❑	❑	❑
See bright lines or flashes	❑	❑	❑
Change in sleep habits	❑	❑	❑
Difficulty reading/writing	❑	❑	❑
Difficulty chewing	❑	❑	❑
Difficulty with speech	❑	❑	❑
Loss of consciousness	❑	❑	❑

Cranial Nerves	Yes	No	Don't Know
Change in smell	❑	❑	❑
Double vision	❑	❑	❑
Blurred vision	❑	❑	❑
Temporary blindness	❑	❑	❑
Ringing in the ears	❑	❑	❑
Difficulty swallowing	❑	❑	❑
Spinning sensation	❑	❑	❑
Diminished hearing	❑	❑	❑
Altered facial sensation	❑	❑	❑
Facial weakness	❑	❑	❑

Motor	Yes	No	Don't Know
Trouble standing from a chair	❑	❑	❑
Difficulty reaching overhead	❑	❑	❑
Difficulty using hands/feet	❑	❑	❑
Loss of muscle bulk	❑	❑	❑
Involuntary shaking of hands	❑	❑	❑
Muscle twitching	❑	❑	❑
Incoordination	❑	❑	❑
Difficulty with your balance	❑	❑	❑
Muscle pain or cramps	❑	❑	❑

Sensory	Yes	No	Don't Know
Numbness or tingling of the face or body	❑	❑	❑
Numbness or tingling of the arms or legs	❑	❑	❑
Pain in the face, arms, legs, or trunk	❑	❑	❑
Difficulty controlling bowels or bladder	❑	❑	❑

Systemic	Yes	No	Don't Know
Weight gain	❑	❑	❑
Weight loss	❑	❑	❑
Intolerance to cold	❑	❑	❑
Intolerance to heat	❑	❑	❑
Sweats	❑	❑	❑
Swollen glands	❑	❑	❑
Skin rash	❑	❑	❑
Shortness of breath	❑	❑	❑
Chest pain	❑	❑	❑
Palpitations	❑	❑	❑
Nausea	❑	❑	❑
Vomiting	❑	❑	❑
Constipation	❑	❑	❑
Diarrhea	❑	❑	❑
Swollen joints	❑	❑	❑

FUNCTIONAL STATUS:

Have you experienced any change in your ability to do your usual activities at home, at work, exercising, or doing your hobbies? Yes_____ No_____
If yes, please explain:

____

____

Do you wish a copy of the evaluation report to be sent to your physician? Yes_____ No_____
If yes, please provide your doctor's full name and address.

____

____

____

Please list all the physicians that should receive a copy of your consultation letter:

Referring Physician:______________________________

Tel:______________________________

Fax:______________________________

Primary Care Physician:______________________________

Tel:______________________________

Fax:______________________________

Other Provider:______________________________

Tel:______________________________

Fax:______________________________

Date of Evaluation:______________________________

INSTRUCTIONS TO ATTENDING PHYSICIAN:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note, however the questionnaire may be referenced for additional details.

Attending Physician Signature Date

____

THANK YOU FOR TAKING YOUR TIME TO COMPLETE THIS QUESTIONNAIRE.

UCSF Medical Center

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

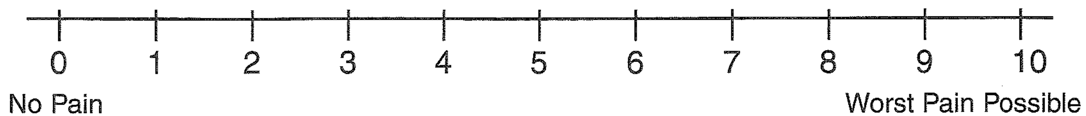
PATIENT PAIN SCREENING RECORD

Have you experienced any pain within the past week? No ☐ Yes ☐

(If "No," stop here and give this to your provider. If "Yes," please answer the rest of the questions)

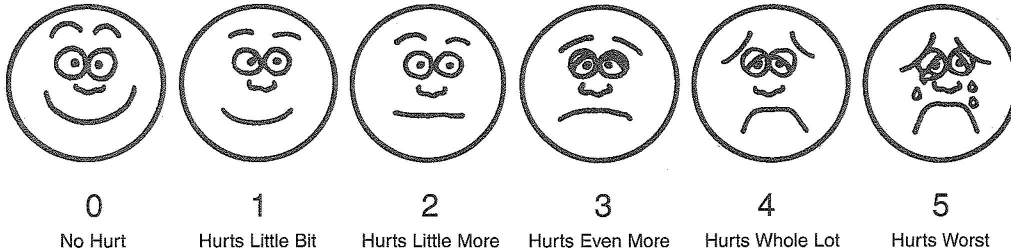
Where is your pain? ______________________________

Circle a number from 0-10 that best describes how much pain you are having now.



For a child or non-English speaking adult, use Wong-Baker FACES Pain Rating Scale©

Ask the patient to circle the face that best describes how he/she feels:



0	1	2	3	4	5
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

What does your pain feel like? **Circle response:** sharp dull burning aching throbbing tender numb stabbing gnawing shooting exhausting penetrating miserable unbearable continuous occasional

What makes the pain better? ______________________________

What makes the pain worse? ______________________________

Are you currently taking medication(s) or using some type of treatment for pain relief? No ☐ Yes ☐

If yes, list medication and/or treatment: ______________________________

STOP HERE

TREATMENT PLAN / RESPONSE:

____

____

____

____

Signature ______________________________ Date ____________

775-075 (Rev. 7/04) ORIGINAL MEDICAL RECORD COPY YELLOW – PRACTICE COPY

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UCSF Medical Center

TERMS AND CONDITIONS OF SERVICE: ADMISSION, MEDICAL SERVICES AND FINANCIAL AGREEMENT

UNIT NUMBER

PT. NAME

BIRTHDATE

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7. **FINANCIAL AGREEMENT:** I understand that even if I have insurance, I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the service I receive, I agree to pay The Regents of the University of California for professional, hospital and clinic services, including UCSF Medical Center physician services, in accordance with the regular rates and terms of UCSF Medical Center. I also agree to pay for other professional services provided at UCSF Medical Center by other health care providers. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements and/or charity care. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.
8. **ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS):** I authorize and direct payment to UCSF Medical Center of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for UCSF Medical Center services, including emergency services, at a rate not to exceed UCSF Medical Center actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to UCSF Medical Center by me.

   I have read, agreed to and received a copy of this Terms and Conditions of Service.

Signature of Patient or Signature of Patient Representative

Signature of Witness (required if patient unable to sign)

Relationship of Representative to Patient

Signature of Interpreter

Language used

Date of Signing

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement (Paragraph 7) and Assignment Of Benefits (Including Medicare Benefits) (Paragraph 8) set forth above.

Date | Financially Responsible Party | Witness

Elective Section:

PATIENT RIGHTS NOTICE: (applies to inpatient admissions only)

Would you like your agent under a durable power of attorney for health care or your next of kin to receive a copy of the Patient Rights and Responsibilities Notice? If so, please contact the Patient Relations Department at (415) 353-1936.

876-037B (Rev. 08/07) WorkflowOne ORIGINAL - MEDICAL RECORD COPY YELLOW - PATIENT COPY

UCSF Medical Center

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

The UCSF Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we have provided you, copies of the current notice are available by accessing our website at http://www.ucsfhealth.org and may be obtained throughout UCSF Medical Center.

I acknowledge that I have received the Notice of Privacy Practices.

______________________________ Signature of Patient or Patient's Representative

____/____/____ Date

______________________________ Print Name

______________________________ Relationship to Patient

______________________________ Name of Interpreter (if applicable)

If written acknowledgement is not obtained, please check reason:

☐ Notice of Privacy Practices Given - Patient Unable to Sign

☐ Notice of Privacy Practices Given - Patient Declined to Sign

☐ Other ______________________________

______________________________ Signature of UCSF Representative

____/____/____ Date

______________________________ Print Name

______________________________ Department

WHITE – MEDICAL RECORD YELLOW – PATIENT OR PATIENT'S REPRESENTATIVE

870-060 (Rev 8/04)