Neurology Center of Salem

A Service of SALEM REGIONAL MEDICAL CENTER

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Dear Patient:

Appointment Date/Time:

Please complete the enclosed questionnaire and mail it back to our office **before** your appointment. This will speed up your first time registration. If we do not receive your questionnaire prior to your appointment with our office, **your appointment will be cancelled**.

If you cannot keep your appointment, kindly give us a 24-hour notice to cancel or reschedule your appointment so that we can use your slot for another patient.

If you have had any MRIs, CTs, NCSs, EMGs, EEGs or any labs done in the past, please request those records and bring them with you to your appointment. You will also need to obtain a CD of your imaging reports (MRIs or CTs only) to bring with you to your appointment. Please call the facility where the MRI or CT was performed to request a CD of the test. If you have had any of the above testing done at Salem Regional Medical Center, you **DO NOT** need to obtain any of your records; inform our office by phone and we will obtain the necessary information for you.

Be sure to bring a list of your current medications and dosage, your insurance cards and a photo ID to your appointment. Any insurance co-payments and/or deductibles are due at the time of your visit. If you are a self pay patient, please call our office for details prior to your scheduled visit.

Please wear shoes, socks or stockings that are easily removable to all of your appointments.

We are looking forward to helping you achieve your optimum health potential.

Thank You,

Dr. Chaohua Yan and staff

Neurology Center of Salem: Patient Screening Questionnaire

Patient Name: _____ Age: _____ Date of Birth: _____Date of Visit: _____

Home Phone: _____ Cell Phone: _____ Sex: F / M

Home Address: _____

Referring Physician: Dr. _____Office Phone: _____
Office Address: _____

Family Physician: Dr. _____ Office Phone: _____
Office Address: _____

Reason of Visit: _____
_____
_____
_____

Previous Medical History: _____
_____
_____
_____

Previous Surgery: Please list all surgeries with date
Type_____ Date: _____
Type_____ Date: _____
Type_____ Date: _____
Type_____ Date: _____
Type_____ Date: _____

Social History: Occupation: _____; Cigarette: no / yes: _____packs per day for _____years. Alcohol: no / yes: occasionally / regularly: _____; recreational drugs: no / yes:
_____

Family Medical History:
Mother's age_____; if deceased, age of death_____; cause of death _____
Father's age _____; if deceased, age of death_____; cause of death_____
Do you have siblings (brother or sister)? Yes / No. If yes, number living_____; number deceased_____
Do you have children? Yes / No. If yes, number living_____; number deceased_____

Do any family members (living or deceased) have the following condition? If yes, who.
High blood pressure_____; Diabetes_____
Multiple sclerosis_____; Cancers_____
Heart attack / Coronary Disease_____; Stroke_____
Migraine headache_____; Tremor_____
Parkinson's disease_____; Neuropathy / muscle disease_____

List any other diseases that run in your family_____
_____

Allergy History:
Are you allergic to any medication or anything else? Yes / No. If yes, list all the items you are allergic to and the corresponding reactions:

_____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____

Medication History:
Are you taking any medications, currently. Yes / No. If yes, list all the medications including over the counter medications you are taking currently.

Medication Name	**Dose**	**Frequency**

ARE YOU **CURRENTLY** EXPERIENCING ANY OF THE FOLLOWING? (Check all that apply)

Constitutional
___recent weight loss (amt___)
___recent weight gain (amt___)
___weakness
___fatigue
___night sweats
___fever
___insomnia

Skin/Breasts
___rashes
___hives
___change in skin color
___lumps
___nipple discharge
___change in breast size
___birthmarks / moles

Musculoskeletal
___joint pain or stiffness
___artificial joints
___bone fractures
___osteoporosis
___leg / foot pain
___back pain
___other _____

Eyes
___glaucoma
___cataracts
___visual loss
___eye pain
___blurred vision
___double vision
___other_____

Lungs / Respiratory
___asthma/bronchitis/emphysema
___shortness of breath
___chronic cough
___coughing up blood
___tuberculosis
___other_____
___other_____

Endocrine
___thyroid problem
___heat / cold intolerance
___hair loss /gain
___excessive sweating
___diabetes
___weight loss /gain
___other_____

Ears/Nose/Throat
___hearing loss
___ringing in the ears
___frequent ear infection
___nose bleed
___hoarseness
___sinus problems
___sore throat
___dental problems
___other_____

Cardiology
___chest pain
___heart murmur
___rheumatic fever
___high blood pressure
___swelling in ankles
___pacemaker /defibrillator
___rapid /irregular heartbeat
___artificial heart valve
___other_____

Hematologic/Blood
___bruise easily
___bleeding problems
___blood clots leg/lungs
___frequent infections
___swollen glands
___blood transfusion
___anemia
___other_____
___other_____

Nervous system
___difficulty concentrating
___headache
___dizziness
___fainting
___numbness / tingling
___seizures / convulsions
___memory problems
___tremor / involuntary movement
___clumsiness / unsteady
___speaking problems
___head injury
___other_____

Gastrointestinal
___loss of appetite
___heartburn or indigestion
___stomach pain
___frequent nausea / vomiting
___recurrent diarrhea
___constipation
___bloody stool
___black, tarry stools
___difficulty swallowing
___jaundice
___hepatitis
___other_____

Genitourinary
___difficulty urinating
___frequent urination
___painful urination
___recurrent bladder infections
___vaginal itching / discharge
___sexual problems
___blood in urine
___venereal disease
___other_____
___other_____
___other_____
___other_____

Immunologic
___hives
___rheumatoid arthritis
___lupus
___facial swelling
___other_____
___other_____
___other_____
___other_____

Other
___radiation therapy
___tumors
___AIDS / HIV
___cancer
___other_____
___other_____
___other_____
___other_____

Psychosocial
___depression
___anxiety
___nightmares
___work / family problems
___tire easily
___trouble concentrating
___insomnia
___other_____

Thank you. This information will help your doctor manage your medical care. All information is strictly confidential and will become part of your medical record.

PERSON COMPLETING THE FORM (if other than the patient) _____

SIGNATURE OF PATIENT_____ **DATE:** _____

PHYSICIAN SIGNATURE_____ **DATE:** _____