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Arete Neurosurgical, PC
1601 East 19th Ave, Ste 4600
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Patient Information

Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Sex: Male: _____ Female: _____ Marital Status: *(circle one)* Single Married Divorced Widowed
Social Security Number: _____-_____-_____ Employer: _____

Referring Physician: _____ **Phone**: _____
Address: _____
City: _____ State: _____ Zip: _____

Primary Care Physician: _____ **Phone**: _____
Address: _____
City: _____ State: _____ Zip: _____

Father / Husband (circle one)
Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Social Security Number: _____-_____-_____ Employer: _____

Mother / Wife (circle one)
Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Social Security Number: _____-_____-_____ Employer: _____

Emergency Contact (Someone not living with you)
Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Insurance Information:

Insurance Company Name: _____
Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Name of Subscriber: _____ Relationship to patient: _____
Subscriber Number: _____ Group Number: _____

Secondary Insurance Information:

Insurance Company Name: _____
Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Name of Subscriber: _____ Relationship to patient: _____
Subscriber Number: _____ Group Number: _____

I certify to the accuracy of the above patient information and understand that I am personally responsible for the full amount of my charges regardless of insurance coverage. I authorize the release of any medical or other information necessary to process claims. I further authorize payment of medical benefits directly to the physician.

Patient/Parent Signature _____ **Date** _____

Arete Neurosurgical Adult Health History Questionnaire

Name: _____ **Date of Birth:** _____

Family History ***Circle any of the diseases the patient's parents, grandparents, uncles, aunts, brothers or sisters have had:***
AIDS, Alcohol, Drug Addiction, Allergies, Anemia, Asthma, Birth Defects, Bleeding Tendency, Cancer, Chronic Lung Disease, Diabetes, Heart Disease, Hepatitis, High Blood Pressure, Inherited Diseases, Kidney Disease, Leukemia, Mental Illness, Migraine Headaches, Peptic Ulcer, Seizures, Thyroid Trouble, TB.

Are the patient's parents both in good health? . . . . . No Yes
How many people live in your home? . . . . . _____
List the number of children the patient have. . . . . _____

Allergies
Has he/she ever had eczema or hives? . . . . . No Yes
Has he/she ever had wheezing or asthma? . . . . . No Yes
Has he/she had any allergies or reactions to the following?
Food . . . . . No Yes
If yes, list the names _____
Medicines . . . . . No Yes
If yes, list the names _____
Latex . . . . . No Yes
IV Contrast Dye? . . . . No Yes
Anesthesia . . . . . No Yes

Past /Current History ***Circle any of the following the patient has had:*** Anemia, Arthritis, Baclofen Pump, Back Surgery, Back Trouble, Bladder Infections, Bleeding Tendency, Blood Transfusion, Brain Surgery, Broken Bones, Bronchitis, Cancer, Diphtheria, Frequent Constipation, Diarrhea, Ear Infections, German 3 Day Measles, Hay Fever, Sinusitis, Heart Disease, Hemorrhoids, Hepatitis, High Blood Pressure, HIV Exposure, Infectious Mono, Kidney Disease, Lead Poisoning, Meningitis, Mumps, Neck Surgery, Nosebleeds, Pacemaker, Pneumonia, Polio, "Red"/"Hard" Measles, Removal of Tonsils/Adenoids, Rheumatic/Scarlet Fever, Seizures, Shunted Hydrocephalus, TB or TB Exposure, Ulcer, Whooping Cough.

List any Others
Does the patient have any metal in their body? . . No Yes
Is the patient claustrophobic? . . . . No Yes

Operations _____
Diseases _____
Injuries _____
Hospitalizations _____

List any current medications the patient is taking.
_____
_____

List any over-the-counter, herbs/vitamins the patient is taking.
_____
_____

Have you recently experienced any of the following:
Circle "**YES**" or "**NO**", if in doubt, leave blank

General

Tire easily, weakness	Yes	No
Marked weight change	Yes	No
Night sweats	Yes	No
Persistent fever	Yes	No
Sensitivity to heat	Yes	No
Sensitivity to cold	Yes	No

Skin

Eruption (rash)	Yes	No
Change in color	Yes	No
Change in hair	Yes	No
Change in nails	Yes	No

Eyes

Trouble seeing	Yes	No
Eye pain	Yes	No
Inflamed eyes	Yes	No
Double vision	Yes	No
Worn glasses	Yes	No

Ears

Loss of hearing	Yes	No
Ringing in ears	Yes	No
Discharge	Yes	No

Nose

Loss of smell	Yes	No
Frequent colds	Yes	No
Obstruction	Yes	No
Excess discharge	Yes	No
Nosebleeds	Yes	No

Mouth

Sore gums	Yes	No
Soreness of tongue	Yes	No
Dental problems	Yes	No

Throat

Post nasal drainage	Yes	No
Soreness	Yes	No
Hoarseness	Yes	No

Breasts

Lumps	Yes	No
Discharge	Yes	No

Cardio-Respiratory System

Cough, persisting	Yes	No
Sputum (Phlegm)	Yes	No
Bloody sputum	Yes	No
Wheezing	Yes	No
Chest pain or discomfort	Yes	No
Pain while breathing	Yes	No
Shortness of breath	Yes	No
Diffculty breathing while lying down	Yes	No
Swelling of ankles	Yes	No
Bluish fingers or lips	Yes	No
High Blood Pressure	Yes	No
Palpitations (abnormal feel of heart beat)	Yes	No
Vein trouble	Yes	No

Digestive System

Change in appetite	Yes	No
Eat items not considered food (Clay, Paint, Dirt, etc)	Yes	No
Difficulty swallowing	Yes	No
Heartburn	Yes	No
Abnormal distress	Yes	No
Belching or excess gas	Yes	No
Abnormal enlargement	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Vomiting of blood	Yes	No
Rectal bleeding	Yes	No
Tarry stools	Yes	No
Dark urine	Yes	No
Jaundice	Yes	No
Constipation	Yes	No

Genitourinary System

Increase in frequency of urination (day)	Yes	No
Increase in frequency of urination (night)	Yes	No
Feel need to urinate without much urine	Yes	No
Unable to hold urine	Yes	No
Pain or bleeding	Yes	No
Blood in urine	Yes	No
Albuminuria	Yes	No

Endocrine

Thyroid trouble	Yes	No
Adrenal trouble	Yes	No
Cortisone treatment	Yes	No
Diabetes	Yes	No

Locomotor

Muscle cramps	Yes	No
Muscle weakness	Yes	No
Pain in joints	Yes	No
Swollen joints	Yes	No
Stiffness	Yes	No
Deformity of joints	Yes	No

Nervous System

Headaches	Yes	No
Dizziness	Yes	No
Fainting	Yes	No
Convulsions or fits	Yes	No
Nervousness	Yes	No
Depression	Yes	No
Change in sensation	Yes	No
Memory loss	Yes	No
Poor coordination	Yes	No
Weakness or paralysis	Yes	No

Sleep Disorders

Snoring	Yes	No
Excessive sleepiness	Yes	No
pauses in breathing while sleeping	Yes	No
Insomnia	Yes	No
Sleeplessness	Yes	No

GYN-OB

*Started menstruating at age _____
*Date of last period_____
*Interval between periods _____days
*Duration of period _____days

Flow: Light Medium Heavy
*Pain with periods Yes No
*Duration of pain _____

What is the Major Reason for today's visit?

_____
_____
_____
_____
_____
_____

Completed By:_____
Parent / Guardian's Signature Date

Reviewed By: _____
MD/NP/RN's Signature Date