

TEXAS NEUROLOGY

6301 GASTON AVE, SUITE 100, WEST TOWER, DALLAS, TEXAS 75214
PHONE 214-827-3610 FAX 214-821-4017

PLEASE COMPLETE THE ENCLOSED INFORMATION TO THE BEST OF YOUR ABILITY **PRIOR** TO YOUR INITIAL CONSULTATION WITH **DR. STEVEN HERZOG**. PLEASE FEEL FREE TO CONTACT DR. HERZOG'S CLINICAL STAFF WITH ANY QUESTIONS RELATING TO THE INFORMATION CONTAINED WITHIN THIS PACKET.

IT IS VERY IMPORTANT THAT YOU BRING YOUR INSURANCE CARD(S) AND ID ON THE DAY OF YOUR APPOINTMENT. PLEASE REMEMBER THAT IT IS YOUR RESPONSIBILITY TO OBTAIN A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN (IF YOUR INSURANCE REQUIRES IT).

AS A COURTESY REMINDER, WE WILL CALL YOU TWO (2) DAYS BEFORE YOUR SCHEDULED APPOINTMENT TO CONFIRM YOUR APPOINTMENT DATE AND TIME. IF FOR ANY REASON YOU CANNOT MAKE YOUR APPOINTMENT, PLEASE CALL AT LEAST 24 HOURS IN ADVANCE TO CANCEL OR RESCHEDULE. IT IS THE POLICY OF TEXAS NEUROLOGY THAT ALL PATIENTS WHO DO NOT PROVIDE 24 HOURS ADVANCED NOTIFICATION OF CANCELLATION WILL BE SUBJECT TO THE FOLLOWING FEES:

NEW PATIENTS/CONSULTATIONS - \$50
TESTING - \$50
FOLLOW UP APPOINTMENTS - \$25

PLEASE CHECK IN ON THE 1ST FLOOR, SUITE 100.
THANK YOU AND WE LOOK FORWARD TO SEEING YOU!

APPT DATE: _____ APPT TIME: _____ PHYSICIAN: STEVEN HERZOG, M.D.

PATIENT REGISTRATION

TEXAS NEUROLOGY

Physician you are seeing today: _____ Today's Date: _____

NAME: _____ DATE OF BIRTH: _____
First MI Last

Address _____ City State Zip

Home Phone (_____) Business Phone (_____) Age _____

Sex _____ Marital Status _____ SS# _____ - _____ - _____ Email: _____

Ethnicity: Caucasian African American Asian/Pacific Islander Hispanic Other

Referring Doctor _____ Phone (_____) _____

Primary Care Doctor _____ Phone (_____) _____

Pharmacy Information _____ Phone (_____) _____

EMPLOYER: _____ OCCUPATION: _____

Address _____ City State Zip

Emergency Contact: _____ Phone Number (_____) _____ Relationship _____

**Is there anyone you would like to authorize us to speak with concerning your medical information?
We will speak only to you if none is selected.**

None Name _____ Contact Number (_____) _____ Relationship _____

Is it ok to leave personal/medical information on your voicemail? Home Mobile Work None

Please provide a current picture id and insurance card(s) to the receptionist at time of arrival. You are required to provide your active insurance card or payment will be required at time services are rendered. Thank you for your cooperation.

For Office Use Only:
Insurance Card Received: _____
Staff Initials

INSURANCE AUTHORIZATION: I HEREBY AUTHORIZE TEXAS NEUROLOGY, P.A. TO FURNISH MEDICAL RECORDS &/OR TEST RESULTS INCLUDING HIV STATUS, VIA FAX OR MAIL, TO MY REFERRING DOCTOR, INSURANCE COMPANIES AND TO THE DOCTOR TO WHOM I AM REFERRED CONCERNING MY ILLNESS AND TREATMENT. I WILL NOT HOLD TEXAS NEUROLOGY OR ITS EMPLOYEES RESPONSIBLE FOR ANY MISDIRECTED RECORDS OR CORRESPONDENCE. I UNDERSTAND THAT ALL PAYMENTS &/OR COPAYMENTS INCLUDING NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVICE, UNLESS I AM COVERED UNDER A WORKERS' COMPENSATION CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO TEXAS NEUROLOGY, P.A. FOR ALL SERVICES RENDERED.

BY SIGNING THIS FORM I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE PATIENT INDICATED ON THIS FORM.

Signature _____

Date _____

PATIENT HISTORY

Name _____ Present Age _____ DOB _____

Appointment Date _____ Referring Doctor _____

Unless you object, a copy of the clinic notes will be sent to the referring physician.

Please check here () if you do **NOT** want that.

Please use the back of this page to list any other physicians who should receive copies.

Other Neurologists or Health Care providers that you have seen for Headache Management:

Primary Care Doctor (Full Name): _____

CHIEF COMPLAINT: Please write a concise statement describing the neurological condition, symptoms, or diagnosis (the reason for neurological consultation).

HEADACHE HISTORY

➤ ONSET:

Headaches first began: In Childhood In Teens Between 20 – 30 Between 30 – 50 Over 50

➤ LOCATION: (Check where appropriate)

Left Side _____ Right Side _____ Either Side _____ All Over _____

Hatband _____ Face/Jaw _____ Neck _____

Usually stays in one place _____ Sometimes moves around _____ Often moves around _____

➤ TIMING: (Check where appropriate)

Daily _____ Weekly _____ Monthly _____

➤ DURATION: (Please indicate duration below)

Headaches Last _____ (hours/days) If not treated

_____ (hours/days) If treated immediately

_____ (hours/days) If treated after they are severe

Free From Headaches From _____ years to _____ OR _____ Never free of headaches

➤ SEVERITY: DOES YOUR HEADACHE:

		Never	Sometimes	Often
Headaches range from:	Require bed rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mild _____	Make you miss work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moderate _____	Difficult to do household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe _____	Make you miss exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	Make you miss routine activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SH _____ AP _____ JM _____

Revised Date: 02/02/2010

➤ **QUALITY:** (Check where appropriate)

Achy _____	Crushing _____	Deep Pain _____	Dull _____
Lightning Bolts _____	Piercing _____	Pounding _____	Pressure Like _____
Pulsating _____	Sharp _____	Squeezing _____	Stabbing _____
Throbbing _____	Other _____		

➤ **ASSOCIATED SYMPTOMS:** (Check where appropriate)

Light Sensitivity _____	Sound Sensitivity _____	Smell Sensitivity _____
Queasiness _____	Nausea _____	Vomiting _____
Joint Pain _____	Limits Activity _____	Dizzy/Light Headed _____
Visual Changes _____	Vertigo _____	Nasal Congestion _____
Nasal Discharge _____	Red Teary Eye _____	Neck Pain _____
Muscle Spasms _____	Other _____	

➤ **DO ANY OF THE FOLLOWING OCCUR BEFORE THE HEADACHES PAIN DEVELOPS?**

- Soft Touch Hurts
- Changes in Vision
- Blind Spots
- Loss of Vision
- Numbness or Tingling of any Body Part
- Difficulty Speaking
- Difficulty Concentrating
- Nausea
- Vomiting
- Diarrhea
- Nasal Congestion
- Sensitivity to Light
- Sensitivity to Noise
- Sensitivity to Smell
- Light-Headedness
- Neck Movements that Aggravate Pain
- Neck Muscles that are Tender to Touch
- Loss of Consciousness
- Exercise Aggravates the Pain
- Weakness of Any Body Part
- Decreased Ability to Move your Neck
- Running Nose on Pain-Side of Head
- Hyperactivity
- Forehead Sweating on Pain-Side of Head
- Small Pupil Size on Pain-Side of Head
- Muscle Aching
- Droopy Eye-Lid on Pain-Side of the Head
- Eye Tearing on Pain-Side of the Head
- Red Eye on Pain-Side of Head
- Puffy Eyelid on Pain-Side of the Head
- Stuffy Nose on Pain-Side of the Head
- Cravings of Sweets

Do you get similar warning symptoms AFTER a headache starts? If so, what are they? _____

Do you get warning symptoms WITHOUT headache pain? _____

➤ **MODIFYING/PRECIPIATING FACTORS:**

Headaches can be brought on or triggered by:

Airplane Travel _____	Alcohol _____	Bending _____	Certain Foods _____
Medications _____	Weather _____	Chewing _____	Cold _____
Coughing _____	Exercise _____	Exertion _____	Fatigue _____
Heat/Sun Exposure _____	Lifting _____	Lying Down _____	Menstruation _____
Missing Meals _____	MSG _____	Nitrates _____	Personal Hygiene _____
Preservatives _____	Sexual Activity _____	Shaving _____	Smells/Odors _____
Smoke _____	Sneezing _____	Stooping _____	Stress/Tension _____
Talking _____	Undersleeping _____	Other _____	

➤ **WHAT ACTIONS HELP RELIEVE YOUR HEADACHES?**

- Rest
- Exercise
- Quiet and Darkness
- Cold Compress
- Massage
- Warm Shower
- Pressure over headache area
- Ice
- Cold Shower

➤ **SEASONALITY:** (Check where appropriate) **NOTES:**

Most Frequent In:

- Spring _____
- Summer _____
- Fall _____
- Not Seasonal _____

➤ PREVIOUS HEAD INJURY: Yes No

Date of Occurrence: _____ Type of Injury: _____

➤ WERE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

- Migraines Cluster Headache Tension Headache Chronic Daily Headache
- Sinus Headache TMJ Trigeminal Neuralgia (tic doloureux)

➤ HAVE YOU HAD A CHANGE IN HEADACHES?

Frequency: Increase _____ Decrease _____ No Change _____
 Severity: Increase _____ Decrease _____ No Change _____
 Character Yes _____ No _____

➤ HEADACHE IMPACT ON YOUR FAMILY, PERSONAL, OR WORK LIFE:

None _____ Slight _____ Moderate _____ Severe _____

➤ ANY PERSONAL HISTORY OF MENTAL AND/OR PHYSICAL ABUSE YOU HAVE EXPERIENCED?

- Mental: Yes No
- Physical: Yes No
- Sexual: Yes No

Discuss with medical provider if necessary: _____

➤ HAVE YOU EXPERIENCED ANY OF THE FOLLOWING EVENTS IN THE PAST YEAR?

- | | | | |
|--------------------------------|--|----------------------------|--|
| Death of Spouse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Personal Injury or Illness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Divorce | <input type="checkbox"/> Yes <input type="checkbox"/> No | Marriage | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Marital Separation | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of Job through firing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Jail Term | <input type="checkbox"/> Yes <input type="checkbox"/> No | Marital Reconciliation | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Death of a close family member | <input type="checkbox"/> Yes <input type="checkbox"/> No | Retirement | <input type="checkbox"/> Yes <input type="checkbox"/> No |

➤ DO YOU HAVE ANY BELIEFS ABOUT YOUR HEADACHES AS A DIRECT RESULT OF YOUR CULTURE/UPBRINGING? Yes No

Describe: _____

➤ IN THE PAST 6 MONTHS:

Recent weight gain: _____ pounds
 Recent weight loss: _____ pounds
 Weight remains stable: Yes No

➤ HOW MUCH CAFFEINE DO YOU DRINK PER DAY?

	<u>Quantity</u>	<u>Type</u>
Cups	_____	_____
Glasses	_____	_____
Other	_____	_____

➤ ARE YOU ON A SPECIAL DIET? Yes No

Explain: _____

➤ HOW MANY MEALS A DAY DO YOU USUALLY EAT?

One Two Three Four or more Varies Snacks

➤ LIST BELOW THE FOODS AND BEVERAGES THAT REPRESENT A TYPICAL DAY FOR YOU:

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Typical Snack: _____

Which, if any particular foods, do you strongly crave? _____

Amount of Water you drink daily: _____ Soda: _____ Dairy: _____ Coffee/Tea: _____

How often do you eat out weekly? _____

Do you use artificial sweeteners? Yes No

➤ IS THERE ANYTHING ELSE YOU WOULD LIKE TO DISCUSS? Yes No

Please explain: _____

SLEEP ISSUES

➤ WHEN GOING TO BED FOR THE NIGHT, DO YOU FALL ASLEEP EASILY? Yes No

➤ WHEN YOU AWAKE, DO YOU FEEL REFRESHED AND ALERT? Yes No

➤ DO YOU SNORE? Yes No

➤ DO YOU GENERALLY?

Sleep through the night _____ Awaken frequently _____

➤ HAVE YOU EVER BEEN DIAGNOSED WITH A SLEEP DISORDER? Yes No

If yes, which one? _____

➤ HAVE YOU EVER HAD A FORMAL SLEEP STUDY? Yes No

If yes, what was the date? _____

➤ **NONPHARMACOLOGIC APPROACHES TO HEADACHE MANAGEMENT:**

Have you ever incorporated any of the following into your headache management and treatment?

- | | | | | | | | |
|-------------------------|------------------------------|-----------------------------|----------------|--------------------------|------------------------------|-----------------------------|----------------|
| Education/support group | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ | Counseling/psychotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ |
| Biofeedback | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ | Relaxation Training | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ |
| Dietary Manipulation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ | Herbal Remedies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ |
| Yoga | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ | Spiritual Guidance | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ |
| Exercise | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ | Tai Chi | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ |
| Acupuncture | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ | Chiropractic Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ |
| Physical Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ | TENS units | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ |
| Therapeutic Massage | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ | Myofascial Release | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ |
| Other | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Effective_____ | | | | |

If other, please explain: _____

➤ **WOMEN'S ISSUES:**

- | | |
|--|--|
| What was the first date of you last menstrual cycle? _____ | How long does your menstrual cycle last? _____ |
| Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you attempting or intending to get pregnant in the next 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you Breast Feeding? <input type="checkbox"/> Yes <input type="checkbox"/> No | Menopause: Pre <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you on Birth Control? <input type="checkbox"/> Yes <input type="checkbox"/> No | Current <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Type: OCP <input type="checkbox"/> Yes <input type="checkbox"/> No | Post <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Injection <input type="checkbox"/> Yes <input type="checkbox"/> No | Hormone Replacement: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Condom <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Other <input type="checkbox"/> Yes <input type="checkbox"/> No | |

- | | |
|------------------------------|---|
| Number of: Pregnancies _____ | Headaches affected by: Better Worse No Change |
| Miscarriages _____ | Menstruation _____ |
| Terminations _____ | Pregnancy _____ |
| Biological Children _____ | Menopause _____ |

SURGICAL HISTORY

➤ **LIST ALL SURGERIES, DATE OF SURGERY, AND NAME OF HOSPITAL WHERE IT WAS PERFORMED:**

DATE	SURGICAL PROCEDURE	NAME OF HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL MEDICAL HISTORY

➤ **HAVE YOU EVER HAD OR ARE YOU CURRENTLY BEING TREATED FOR:**

	<u>Y</u>	<u>N</u>		<u>Y</u>	<u>N</u>		<u>Y</u>	<u>N</u>
Acid Reflex	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Mixed Connective Tissue	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	OCD	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	PFO	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Restless Leg Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Reynaud's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol Problem	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
CODP/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Suicide	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>			
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>			

Other Medical Problems not listed above: _____

➤ **LIST ALL MEDICATIONS TO WHICH YOU ARE ALLERGIC:**

<input type="checkbox"/> I have NO known Medication Allergies.

➤ **LIST ALL THE NON-PRESCRIPTION SUPPLEMENTS, HERBALS, OR VITAMINS YOU TAKE REGULARLY**

FAMILY HISTORY

➤ LIST ANY/ALL CONDITIONS THAT APPLY TO EACH FAMILY MEMBER:

	Mother	Father	Grandparents	Sibling(s)	Children
AIDS/HIV					
Alcoholism					
Alzheimer's					
Anxiety					
Asthma					
Arthritis					
Breast Cancer					
Colon Cancer					
COPD/Emphysema					
Coronary Artery Disease					
Cholesterol Problems					
Clotting Disorder					
Cluster Headache					
Depression					
Diabetes					
Epilepsy					
Fibromyalgia					
Glaucoma					
Headache					
Heart Trouble					
High Blood Pressure					
Kidney Disease					
Liver Disease					
Lupus					
Mental Illness					
Migraines					
Mixed Connective Tissue Disease					
Multiple Sclerosis					
Parkinson's Disease					
Prostate Problems					
Reynaud's Syndrome					
Seizures					
Sickle Cell					
Sleep Disorder					
Stroke					
Suicide					
Thyroid Disease					
Ulcers					
Other_____					

REVIEW OF SYSTEMS

(All boxes must be checked yes or no)

Y/N

CONSTITUTIONAL SYMPTOMS-General

- Fever
- Fatigue
- Headaches

EYES

- Eye disease or injury
- Wear glasses/contact lens
- Blurred or Doubled vision
- Glaucoma

EARS/NOSE/MOUTH/THROAT

- Swollen glands in neck
- Sore throat or voice change
- Mouth sores
- Hearing loss or ringing in the ear
- Earaches or drainage
- Chronic sinus problem or rhinitis
- Nose bleeds

CARDIOVASCULAR

- Swelling in the feet or ankles
- Shortness of breath when walking
- Palpitations
- Chest pain or angina
- Heart trouble

GASTROINTESTINAL

- Peptic ulcer
- Abdominal pain or heartburn
- Rectal bleeding
- Constipation
- Frequent diarrhea
- Irritable bowel syndrome
- Loss of appetite
- Nausea or vomiting

Y/N

MUSCULOSKETAL

- Joint pain
- Joint stiffness or swelling
- Weakness of muscle or joints
- Neck pain
- Muscle pain or cramps
- Back pain
- Cold extremities
- Difficulty walking

SKIN/BREAST

- Rash or itching
- Change in nails and hair
- Varicose veins
- Reynaud's syndrome
- Breast lump

NEUROLOGICAL

- Stroke
- Frequent or recurring headaches
- Lightheaded or dizziness
- Convulsions or seizures
- Numbness or tingling sensation
- Tremors
- Paralysis
- Head injury

PSYCHIATRIC

- Depression
- Memory loss or confusion
- Insomnia
- Anxiety

Y/N

ALLERGIC/IMMUNOLOGIC

History of rash or an adverse reaction to:

- Penicillin or other antibiotic
- Morphine, demoral, narcotics
- Novocain, anesthetics

RESPIRATORY

- Chronic or frequent coughs
- Spitting up food
- Shortness of breath
- Asthma or wheezing

GENTOURINARY

- Sexual difficulty
- Change in force of stream when urinating
- Incontinence or dribbling
- Kidney stones
- Female: history of urinary problems
- Female: irregular menstruation
- Female: pain with menstruation

HEMATOLOGICAL/LYMPHATIC

- Anemia
- Enlarged glands
- Slow to heal after cuts
- Bleeding or bruising tendency
- Phlebitis
- Past blood transfusions

ENDOCRINE

- Glandular or hormone problems
- Thyroid disease
- Diabetes
- Excessive thirst or urination
- Heat or cold intolerance

➤ HAVE YOU HAD ANY OF THESE TESTS?

Y/N	TEST	DATE	WHERE DONE	RESULT
<input type="checkbox"/> <input type="checkbox"/>	MRI Brain	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> <input type="checkbox"/>	CT Scan	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> <input type="checkbox"/>	EEG (Brain wave recording)	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> <input type="checkbox"/>	Evoked Potential Study	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> <input type="checkbox"/>	EMG and Nerve Conductions	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> <input type="checkbox"/>	Cerebral Arteriogram	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> <input type="checkbox"/>	Carotid Doppler	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> <input type="checkbox"/>	Echocardiogram	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> <input type="checkbox"/>	LP (Spinal Tap)	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> <input type="checkbox"/>	Myelogram	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> <input type="checkbox"/>	Blood Tests (specify)	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> <input type="checkbox"/>	Other (specify)	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

HEADACHE IMPACT TEST

This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches. To complete, please check one answer for each question.

1. When you have headaches, how often is the pain severe?
 Never Rarely Sometimes Very Often Always

2. How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?
 Never Rarely Sometimes Very Often Always

3. When you have a headache, how often do you wish you could lie down?
 Never Rarely Sometimes Very Often Always

4. In the past 4 weeks, how often have you felt too tired to do work or daily activities because of headaches?
 Never Rarely Sometimes Very Often Always

5. In the past 3 weeks, have you felt fed up or irritated because of your headaches?
 Never Rarely Sometimes Very Often Always

6. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?
 Never Rarely Sometimes Very Often Always

Total Score: _____ (Higher scores indicate greater impact on your life. Score range is 36 – 84)
(TO BE SCORED BY PROVIDER)

MIDAS QUESTIONNAIRE
DISABILITY ASSESSMENT

This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor find the best treatment for you. Please answer the following questions about all your headaches over the last 3 months. Write your answers next to each question. Write zero if you did not do the activity in the last 3 months.

1. On how many days in the last 3 months did you miss work or school because of your headaches? (if you do not attend work or school enter zero)

_____ Days

2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (do not include days you counted in question 1 where you missed work or school. If you don't attend work or school enter zero)

_____ Days

3. On how many days in the last 3 months did you not do household work because of your headaches?

_____ Days

4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (do not include days counted in question 3, where you did not do household work)

_____ Days

5. On how many days in the past 3 months did you miss family, social, or leisure activities because of your headaches?

_____ Days

TOTAL: _____

(questions 1 – 5)

- A. On how many days in the last 3 months did you have a headache? (if headache lasted more than 1 day, count each day)

_____ Days

- B. On a scale of 0-10, on average, how painful were these headaches? (0= no pain at all, and 10= worst pain)

_____ 0-10

After you have filled out this questionnaire add the total number of days from questions 1-5.

DATE: _____

PATIENT SIGNATURE: _____

FOR OFFICE USE ONLY:

DATE: _____

MD/NP/PA SIGNATURE: _____

TEXAS NEUROLOGY

6301 GASTON AVE, SUITE 100, WEST TOWER, DALLAS, TEXAS 75214

PHONE 214-827-3610 FAX 214-821-4017

TO TEXAS NEUROLOGY FROM THE NORTH

Highway 75 (Central Expressway)

1. Travel south on Highway 75 (North Central Expressway)
2. Exit Mockingbird and turn left (eastbound)
3. Take Mockingbird to Skillman, turn right on Skillman
4. Take Skillman to Oram turn left on Oram, go to 1st stop sign
5. Turn right into parking lot after stop sign.

North Dallas Tollway

1. Take the tollway south, through the toll plazas and continue to downtown.
2. Take Pearl St. exit (left) and follow Pearl St. through downtown for 6 traffic lights until you reach Pacific. Turn left (under Central Expressway).
3. Pacific Street will change into Gaston Ave. After you go under the expressway.
4. Continue down Gaston approximately 2.5 miles to Paulus Ave.
5. Turn left on Paulus, go through one light (La Vista Dr.) turn right into parking lot.

Interstate 35 Stemmons Freeway

1. Travel South on Interstate 35 to the downtown interchange.
2. Follow signs for I-30 East Texarkana. Proceed to merge right.
3. Continue east until you come to the Munger Blvd. exit.
4. Exit Munger Blvd. and turn left.
5. Take Munger to Gaston Ave, turn right onto Gaston.
6. Take Gaston to Paulus, turn left. Go through one light (LaVista Dr.) and turn right into parking lot.

TO TEXAS NEUROLOGY FROM THE WEST

(I-30) Arlington, Grand Prairie, Mid-Cities and Fort Worth

1. Take I-30 East Texarkana.
2. Take the Munger Blvd. exit and turn left.
3. Take Munger Blvd to Gaston Ave. and turn right onto Gaston.
4. Take Gaston to Paulus Ave. and turn left on Paulus.
5. Go through one light (LaVista Dr.), turn right into parking lot.

Highway 114 (DFW Airport Using the North Exit)

1. Travel East down Hwy 114 to the intersection of 183.
2. Take 183 east, then go South on Interstate 35.
3. Proceed onto 75/45 following the Houston signs until you reach 75 North and 75 South directional signs. Exit onto 75 North.
4. Take 75 North to the Haskell exit, turn right onto Haskell.
5. Follow Haskell to Gaston Ave. turn left on Gaston.
Take this approx. 2 miles to Paulus Ave.
6. Turn left onto Paulus.
7. Go through one light (LaVista Dr.), turn right into parking lot.

TO TEXAS NEUROLOGY FROM THE SOUTH

Interstate 35

1. Take 35 North to the downtown interchange and exit I-30 East Texarkana. Proceed to merge right (eastbound).
2. Continue east, exit Munger Blvd. and turn left.
3. Take Munger to Gaston Ave. and turn right.
4. Take Gaston to Paulus Ave. and turn left.
5. Go through one light (LaVista Dr.), turn right into parking lot.

Interstate 20

1. Take I-20 East to 67 North.
2. Take 35 North to the downtown interchange and exit I-30 East Texarkana. Proceed eastbound
3. Exit Munger Blvd., turn left.
4. Take Munger Blvd. to Gaston Ave. Turn right onto Gaston.
5. Take Gaston to Paulus Ave., turn left.
6. Go through one light (LaVista Dr.), turn right into parking lot.

TO TEXAS NEUROLOGY FROM THE EAST

(I-30 East / US 80 East)

1. Take I-30 West, exit Munger Blvd. and turn right.
2. Take Munger to Gaston Ave. turn right onto Gaston.
3. Take Gaston to Paulus Ave. turn left onto Paulus.
4. Go through one light (La Vista), turn right into parking lot.

(Street Directions)

1. Take Buckner Blvd. north, turn left onto Garland Rd.
2. Follow to Gaston Ave. (merge right).
3. Continue on Gaston, pass the Abrams Rd. intersection turn right onto Paulus Ave.
4. Go through one light (LaVista Dr.) and turn right into parking lot.

To Texas Neurology from 635 West /LBJ Freeway

1. Take 635 West, exit Abrams Road, turn right.
2. Take Abrams to Gaston Ave., turn right.
3. Take Gaston to Paulus Ave., turn right.
4. Go through one light (LaVista Dr.), turn right into parking lot.

To Texas Neurology from 635 East/LBJ Freeway

1. Take 635 East, exit Abrams Road, turn left.
2. Take Abrams to Gaston Ave, turn right.
3. Take Gaston to Paulus Ave., turn right.
4. Go through one light (LaVista Dr.), turn right into parking lot.

Interstate 45 (Ennis)

1. Travel north following Sherman signs.
2. Take I-30 East Texarkana.
3. Exit Munger Blvd and turn left.
4. Take Munger to Gaston Ave and turn right onto Gaston.
5. Take Gaston to Paulus turn left on Paulus.
6. Go through one light (LaVista Dr.), turn right into parking lot.

Access to parking is off Paulus Avenue and Alderson Street next to the Wells Fargo Bank Building.
Texas Neurology is located in the WEST TOWER on the 1st FLOOR.