ADVANCED NEUROSCIENCES INSTITUTE

101 Forrest Crossing Blvd Suite 103 Franklin, TN 37064
Phone 615-791-5470 Email: frontdesk@neurosci.us
Dr. Samuel F. Hunter, MD, PhD

CURRENT MEDICAL INFORMATION

LAST NAME:	DATE OF BIRTH:
FIRST NAME:	SOCIAL SECURITY:
TODAY'S DATE:	RELIGION:
PHONE NUMBER:	

Please write in the box the problems you are now having:

Do you have a living will, advance directives, or power of attorney for health care? ☐ *Yes* ☐ *No*

Did a physician send you? ☐ *Yes* ☐ *No*

Physician's Name and Address: _____

Phone: (_____) _____-_____

I have received a copy of the Privacy Policy and am aware my private health care information may be available to insurers, government, and family members ☐ *Yes* ☐ *No*

Signature of patient or legal guardian _____

Name of person completing this form (if not patient) _____ Relationship: _____

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MEDICATIONS

Identify current prescription and non-prescription medications. Include any vitamins, supplements, contraceptives, pain or cold medicines, as well as other remedies):

Name of Medication	Dose (mg)	Times per day taken

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ALLERGIES

Have you ever had a significant reaction to:

☐ *Latex* ☐ *Seafood* ☐ *Rubber*
☐ *Iodine* ☐ *Tape* ☐ *Contrast Dye*
☐ *Other:* _____

Any medication allergy:

☐ *No* ☐ *Yes* *(list here)* →

Medication Allergy	Describe reaction or allergy

Other recent medications: _____

Have you taken cortisone, prednisone, or "steroid" type drugs in the last year? ☐ *No* ☐ *Yes / When?* _____

Have you taken aspirin or aspirin-containing medicines in the last two weeks? ☐ *No* ☐ *Yes / When?* _____

Are there medications other than allergies which had unpleasant side effects? _____

NEW MEDICAL AND SOCIAL INFORMATION

This is my first visit to this clinic: ☐ *Yes* ☐ *No* ***If "No", please answer the following:*** **Last visit:** _____

Any new or worse medical problems since your last visit: _____

Have you seen other doctors since your last visit? ☐ *No* ☐ *Yes* **Whom, When and Why?** _____

Have you started new medications since your last visit? ☐ *No* ☐ *Yes* **Which ones and Why?** _____

Have you had any significant events in your life since your last visit? ☐ *No* ☐ *Yes*

HEALTH CARE PROVIDER REVIEW I have reviewed this form with the patient:

Provider Signature: _____ **Provider Signature:** _____

No: _____ **Date:** _____ **No:** _____ **Date:** _____

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REVIEW OF SYSTEMS

Patients, please check yes or no to the following as related to your current visit
Reviewer, please elaborate where appropriate

Have you had (please check item):	Yes	No	Reviewer's Comments:
Any reactions to ☐ foods ☐ molds ☐ dust ☐ bee stings? What? _____			**Immune:**
A ☐ fever ☐ sore tongue ☐ mouth sores in the last month?			**Constitution:**
A change in weight ☐ up ☐ down more than 10 lbs. in the last 6 mos?			
Any ☐ enlarged glands ☐ goiter ☐ lymph nodes:			**Heme:**
☐ blood clotting disorder, frequent bleeding ☐ gums ☐ nose ☐ bruising?			
A ☐ skin rash ☐ sores ☐ breast lumps ☐ changing moles?			**Integument:**
Noticed a recent change in your ☐ skin ☐ hair texture?			
Great difficulty with feeling ☐ hot ☐ cold when others are comfortable?			**Endocrine:**
Excessive ☐ urination and ☐ thirst? When?_____			
A problem with ☐ disabling pain ☐ fatigue? Where?_____			**Musculoskel:**
☐ Pain or ☐ stiffness in your ☐ joints (which:_____) or ☐ back?			
☐ Double vision or ☐ blurred vision? ☐ Glasses? ☐ Lazy or crossed eye?			**Neuro:**
Problems with ☐ falling ☐ staying asleep or being ☐ too sleepy?			
☐ Severe ☐ frequent headaches? ☐ Funny sensations or ☐ numbness?			
☐ Fainting ☐ falling, other ☐ unusual spells ☐ seizures or ☐ convulsions?			
Difficulty with ☐ slurred speech or ☐ weak ☐ clumsy ☐ arm ☐ leg?			
☐ Tremors ☐ jerks ☐ cramps, or ☐ other abnormal movements?			
Marked difficulty with ☐ memory ☐ confusion, or ☐ expressing yourself?			**Psych:**
Feel ☐ stressed ☐ depressed ☐ tired, or ☐ nervous frequently?			
Problem ☐ hearing ☐ dizziness ☐ hoarseness or with ☐ sinuses?			**ENT:**
Difficulty ☐ eating ☐ drinking ☐ chewing ☐ choking or ☐ swallowing?			
Chest ☐ pain ☐ pressure, abnormal ☐ heart beat ☐ valve, or ☐ murmur?			**Vascular:**
Shortness of breath ☐ at night or ☐ with only a little activity?			
Abnormal swelling of your ☐ ankles or ☐ feet? ☐ Calf pain when walking?			
☐ Asthma ☐ wheezing, or ☐ coughing up ☐ sputum or ☐ blood?			**Respiratory:**
☐ Indigestion ☐ heartburn ☐ nausea ☐ vomiting, or ☐ stomach ulcers?			**Gastrointestinal:**
☐ Constipation ☐ diarrhea, or ☐ blood ☐ changes in bowel movements?			
☐ Burning or ☐ pain when urinating or ☐ bloody urine?			**Urinary:**
Difficulty with ☐ starting urine ☐ emptying bladder, or ☐ leaking urine?			
Difficulty with your sexual function?			
Women only:			**Gyne:**
A ☐ mammogram ☐ Pap smear, and ☐ pelvic examination in the last year?			
☐ irregular menstrual periods or ☐ recent abnormal vaginal discharge?			
Might you be pregnant at this time?			**LMP:**