LOUIS H. MEDVED, MD – NEUROLOGY

PATIENT INFORMATION FORM

Patient Demographics

Patient Name: _____
Date of Birth: ____ / ____ / _____ **Social Security #**_____
Age: _____ **Sex:** ☐ Male ☐ Female ☐ Other
Height: _____ **Weight:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____

Home Phone: _____
Cell Phone: _____
Email Address: _____
Preferred Method of Contact: ☐ Phone ☐ Text ☐ Email

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer/School: _____
Occupation: _____

Emergency Contact
Name: _____
Relationship: _____
Phone Number: _____

Primary Care Provider
PCP Name: _____
PCP Phone: _____
Referring Provider (if different): _____

Insurance Information

Primary Insurance: _____
Subscriber Name: _____
Subscriber DOB: ____ / ____ / _____
Member ID: _____
Group Number: _____

Secondary Insurance: _____
Member ID: _____

Important Insurance Notice

Please read carefully and initial below:
Louis H. Medved, MD – Neurology does **NOT** participate with **No-Fault** or **Workers' Compensation** insurance cases. If your visit is related to a motor vehicle accident or a work-related injury, you will be responsible for payment in full at the time of service unless other acceptable insurance is provided.
Patient Initials: _____

Pharmacy Information

Preferred Pharmacy Name: _____
Pharmacy Phone: _____
Pharmacy Location: _____

MEDICAL HISTORY

Reason for Today's Visit

When did symptoms begin? _____

Have you seen a neurologist before? ☐ Yes ☐ No
If yes, who and when: _____

Prior Neurological Testing

Have you had any of the following? (check all that apply)
☐ MRI Brain
☐ MRI Spine
☐ CT Head
☐ CT Spine
☐ EEG
☐ EMG/Nerve Conduction Study
☐ Sleep Study
☐ Neuropsychological Testing
☐ Lumbar Puncture (Spinal Tap)
☐ Other: _____

Where was testing performed?

Approximate date(s):

Past Medical History (check all that apply)

☐ Headaches/Migraines
☐ Seizures/Epilepsy
☐ Stroke or TIA
☐ Neuropathy
☐ Memory Problems/Dementia
☐ Tremor
☐ Multiple Sclerosis
☐ Parkinson's Disease
☐ Concussion/Head Injury
☐ Diabetes
☐ High Blood Pressure
☐ High Cholesterol
☐ Heart Disease
☐ Depression
☐ Anxiety
☐ Sleep Apnea
☐ Thyroid Disease
☐ Cancer
☐ Other: _____

Past Surgical History

Surgery Year

FAMILY HISTORY

Do any blood relatives have a history of the following?

☐ Migraines
☐ Seizures/Epilepsy
☐ Stroke
☐ Alzheimer's/Dementia
☐ Parkinson's Disease
☐ Multiple Sclerosis
☐ Neuropathy
☐ Brain Tumor
☐ Heart Disease
☐ Diabetes
☐ Other neurological condition: _____

Relationship(s) and details (mother, father, sibling, etc.):

Social History

Tobacco Use: ☐ Never ☐ Former ☐ Current
If current/former — packs per day: _____ years: _____
Alcohol Use: ☐ None ☐ Occasional ☐ Daily
Illicit Drug Use: ☐ No ☐ Yes (specify): _____
Caffeine Intake: ☐ None ☐ 1–2/day ☐ 3+/day
Living Situation: ☐ Alone ☐ With family ☐ Other: _____

Current Medications (Include prescriptions, OTC, vitamins) or attach a list

Medication	**Dose**	**Frequency**

Allergies/Reaction

☐ No Known Drug Allergies

_____

_____

Female Information (Complete if applicable)

Are you currently pregnant? ☐ No ☐ Yes ☐ Unsure
Number of pregnancies: _____
Number of deliveries: _____
Date of last menstrual period (LMP): ____ / ____ / _____
Are you currently breastfeeding? ☐ No ☐ Yes
Are you using birth control? ☐ No ☐ Yes
If yes, type: _____
Are your menstrual cycles regular? ☐ Yes ☐ No