

# PATIENT INFORMATION

**Borgess Neurology**  
1541 Gull Road, Suite 200  
Kalamazoo, MI 49048  
(269) 381.7380

**Borgess Spine**  
3025 Gull Road  
Kalamazoo, MI 49048  
(269) 552.BACK (2225)

**Neurosurgery of Kalamazoo**  
1541 Gull Road, Suite 200  
Kalamazoo, MI 49048  
(269) 343.4879 Referral line

Patient Name (First)		(Middle)		(Last)	
Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status	Today's Date	Referring Physician	
SS#	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both -handed		Phone	Fax	
Patient Address			Patient Employer Name		
City/State/ZIP			Address		
Phone- home	work	cell	City/State/ZIP		Phone
Responsible Party			Family Physician		
Address			Address		
City/State/ZIP			City/State/ZIP		
Phone			Phone		
Responsible Party SS#			Emergency Contact		Phone

## INSURANCE INFORMATION

### PRIMARY INSURANCE (TO BE BILLED FIRST). MUST BE COMPLETED TO BILL INSURANCE

Name of Insurance Company		Group/Claim Number		Copay Amount	
Insurance Company Address		City	State	ZIP	Phone
Card Numbers	Policy Holder Birthdate		Policy Holder Name		SS#

### SECONDARY INSURANCE

Name of Insurance Company		Group/Claim Number			
Insurance Company Address		City	State	ZIP	Phone
Card Numbers	Policy Holder Birthdate		Policy Holder Name		SS#

## WORK OR AUTO ACCIDENT

Is this visit due to a work or auto accident? Yes <input type="checkbox"/> No <input type="checkbox"/>		Date of loss or injury			
Carrier/Insured Name			Claim Number		
Address		City	State	ZIP	Phone
Adjustor Name				Phone	Fax

## QUESTIONS TO ASK MY DOCTOR

Because your health is a priority to us, we want to make sure you get the most out of your Borgess Spine appointment by feeling as informed as possible. So that we can address your specific concerns, please take a few moments to jot down any questions you have regarding your condition or care.

# PATIENT HEALTH HISTORY AND ASSESSMENT

Patient Name (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex  M  F Today's Date \_\_\_\_\_

**CHIEF COMPLAINT**

Describe briefly the main problem for which you are here today.  
 \_\_\_\_\_  
 How long have you had this problem?  
 \_\_\_\_\_  
 Is your condition related to an injury? Yes  No

**BLEEDING**

Do you bleed excessively? Yes  No   
 Do you bruise easily? Yes  No   
 Bleeding disorders in family members? Yes  No

**CORTISONE/PREDNISONE**

Have you had cortisone/prednisone by mouth in the last 12 months? Yes  No

**PAST MEDICAL HISTORY**

**Serious Injuries:** (describe any significant injuries you have had in your life)  
 \_\_\_\_\_ year \_\_\_\_\_  
 \_\_\_\_\_ year \_\_\_\_\_  
 \_\_\_\_\_ year \_\_\_\_\_  
 \_\_\_\_\_ year \_\_\_\_\_

**Surgeries:** (List any previous operations you have had)  
 \_\_\_\_\_ year \_\_\_\_\_  
 \_\_\_\_\_ year \_\_\_\_\_  
 \_\_\_\_\_ year \_\_\_\_\_  
 \_\_\_\_\_ year \_\_\_\_\_

Have you ever had a problem with anesthesia? Yes  No   
 If yes, explain: \_\_\_\_\_

**Medical Conditions:** (Describe any other illnesses you have had, such as diabetes, high blood pressure, heart disease, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have a history of cancer? Yes  No   
 If yes, which type? \_\_\_\_\_

**ALLERGIES**

Do you have any allergies to Medications? Yes  No   
 If yes, please list and describe reaction

Do you have allergies to other substances? Yes  No   
 If yes, please list

Are you allergic to latex? Yes  No   
 Are you allergic to X-ray/contrast dye? Yes  No

**MEDICATIONS LIST**

Medication Name \_\_\_\_\_  
 Dosage \_\_\_\_\_  
 Times per day \_\_\_\_\_  
 Reasons for Prescription \_\_\_\_\_

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 Dosage \_\_\_\_\_  
 Times per day \_\_\_\_\_  
 Reasons for Prescription \_\_\_\_\_



# PATIENT HEALTH HISTORY AND ASSESSMENT

Patient Name (First)	(Middle)	(Last)
Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Today's Date

Do you have any of the following symptoms? If "yes", please explain. Use additional space at the end of this section if needed.

GENERAL	STOMACH (GASTROINTESTINAL)
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Unexplained fever/chills: Yes  No  Explain: \_\_\_\_\_  
 Night sweats: Yes  No  Explain: \_\_\_\_\_  
 Excessive fatigue: Yes  No  Explain: \_\_\_\_\_  
 Sleeping problems: Yes  No  Explain: \_\_\_\_\_  
 Weight gain/loss: Yes  No  Explain: \_\_\_\_\_

Heartburn/indigestion: Yes  No  Explain: \_\_\_\_\_  
 Nausea/vomiting: Yes  No  Explain: \_\_\_\_\_  
 Vomiting blood: Yes  No  Explain: \_\_\_\_\_  
 Change in bowel habits: Yes  No  Explain: \_\_\_\_\_  
 Change in stool color: Yes  No  Explain: \_\_\_\_\_  
 Hemorrhoids: Yes  No  Explain: \_\_\_\_\_  
 Rectal bleeding: Yes  No  Explain: \_\_\_\_\_  
 Colon polyps: Yes  No  Explain: \_\_\_\_\_  
 Blood in stool: Yes  No  Explain: \_\_\_\_\_  
 Jaundice/hepatitis: Yes  No  Explain: \_\_\_\_\_  
 Ulcers: Yes  No  Explain: \_\_\_\_\_  
 Recurrent Abdominal pain: Yes  No  Explain: \_\_\_\_\_

EAR/NOSE/THROAT (ENT)	KIDNEYS (GYNECOLOGIC/URINARY)
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Hearing loss: Yes  No  Explain: \_\_\_\_\_  
 Ringing in ears: Yes  No  Explain: \_\_\_\_\_  
 Drainage from ears/nose: Yes  No  Explain: \_\_\_\_\_  
 Sores in mouth: Yes  No  Explain: \_\_\_\_\_  
 Difficulty swallowing: Yes  No  Explain: \_\_\_\_\_

Lower back pain: Yes  No  Explain: \_\_\_\_\_  
 Flank/side pain: Yes  No  Explain: \_\_\_\_\_  
 Burning with urination: Yes  No  Explain: \_\_\_\_\_  
 Urinary urgency/frequency: Yes  No  Explain: \_\_\_\_\_  
 Kidney/bladder infections: Yes  No  Explain: \_\_\_\_\_  
 Blood in urine: Yes  No  Explain: \_\_\_\_\_  
 Passage of kidney stones: Yes  No  Explain: \_\_\_\_\_  
 Decreased urine stream: Yes  No  Explain: \_\_\_\_\_  
 Hesitancy/dribbling with urination: Yes  No  Explain: \_\_\_\_\_  
 Stress incontinence: Yes  No  Explain: \_\_\_\_\_

EYES	MUSCLES/JOINTS
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Eye pain: Yes  No  Explain: \_\_\_\_\_  
 Glaucoma: Yes  No  Explain: \_\_\_\_\_  
 Visual loss: Yes  No  Explain: \_\_\_\_\_

HEART (CARDIOVASCULAR)	SKIN
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Heart disease: Yes  No  Explain: \_\_\_\_\_  
 High blood pressure: Yes  No  Explain: \_\_\_\_\_  
 Low blood pressure: Yes  No  Explain: \_\_\_\_\_  
 Elevated cholesterol: Yes  No  Explain: \_\_\_\_\_  
 Chest pain/angina: Yes  No  Explain: \_\_\_\_\_  
 Heart racing/skipping: Yes  No  Explain: \_\_\_\_\_  
 Heart attack/failure: Yes  No  Explain: \_\_\_\_\_  
 Heart murmur: Yes  No  Explain: \_\_\_\_\_  
 Rheumatic fever: Yes  No  Explain: \_\_\_\_\_  
 Artificial heart valve: Yes  No  Explain: \_\_\_\_\_  
 Pacemaker: Yes  No  Explain: \_\_\_\_\_  
 Ankle swelling: Yes  No  Explain: \_\_\_\_\_

Swollen/inflamed joints: Yes  No  Explain: \_\_\_\_\_  
 History of gout: Yes  No  Explain: \_\_\_\_\_  
 Artificial joints: Yes  No  Explain: \_\_\_\_\_  
 Deformed joints: Yes  No  Explain: \_\_\_\_\_  
 Severe arthritis: Yes  No  Explain: \_\_\_\_\_

LUNGS (PULMONARY)	PSYCHIATRIC
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Shortness of breath: Yes  No  Explain: \_\_\_\_\_  
 Emphysema: Yes  No  Explain: \_\_\_\_\_  
 Recurrent bronchitis: Yes  No  Explain: \_\_\_\_\_  
 Chronic cough: Yes  No  Explain: \_\_\_\_\_  
 Coughing up blood: Yes  No  Explain: \_\_\_\_\_  
 Tuberculosis (TB): Yes  No  Explain: \_\_\_\_\_  
 Positive TB skin test: Yes  No  Explain: \_\_\_\_\_  
 History of pneumonia: Yes  No  Explain: \_\_\_\_\_  
 Wheezing: Yes  No  Explain: \_\_\_\_\_  
 Asthma: Yes  No  Explain: \_\_\_\_\_

Psychiatric problems: Yes  No  Explain: \_\_\_\_\_  
 Suicidal thoughts: Yes  No  Explain: \_\_\_\_\_

# PATIENT HEALTH HISTORY AND ASSESSMENT

Patient Name (First)	(Middle)	(Last)
Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Today's Date

### GLANDS/HORMONES (ENDOCRINE)

Heat/cold tolerance: Yes  No  Explain: \_\_\_\_\_

Excessive urination: Yes  No  Explain: \_\_\_\_\_

Changes in facial/body hair: Yes  No  Explain: \_\_\_\_\_

Increase in hat/glove size: Yes  No  Explain: \_\_\_\_\_

Thyroid problems: Yes  No  Explain: \_\_\_\_\_

Diabetes: Yes  No  Explain: \_\_\_\_\_

### HEAD/BRAIN (NEUROLOGIC)

Headache: Yes  No  Explain: \_\_\_\_\_

Fainting: Yes  No  Explain: \_\_\_\_\_

Seizures/epilepsy: Yes  No  Explain: \_\_\_\_\_

Memory loss: Yes  No  Explain: \_\_\_\_\_

Speech difficulty: Yes  No  Explain: \_\_\_\_\_

Loss of smell: Yes  No  Explain: \_\_\_\_\_

Facial numbness/weakness: Yes  No  Explain: \_\_\_\_\_

Extremity numbness/weakness: Yes  No  Explain: \_\_\_\_\_

Muscle shrinkage: Yes  No  Explain: \_\_\_\_\_

Muscle cramping/twitching: Yes  No  Explain: \_\_\_\_\_

Dizziness/vertigo: Yes  No  Explain: \_\_\_\_\_

Imbalance: Yes  No  Explain: \_\_\_\_\_

In-coordination: Yes  No  Explain: \_\_\_\_\_

Tremors/Shaking: Yes  No  Explain: \_\_\_\_\_

### BLOOD (HEMATOLOGIC)

Anemia: Yes  No  Explain: \_\_\_\_\_

Enlarged lymph nodes: Yes  No  Explain: \_\_\_\_\_

Abnormal blood cells: Yes  No  Explain: \_\_\_\_\_

Blood transfusions: Yes  No  Explain: \_\_\_\_\_

Transfusion reactions: Yes  No  Explain: \_\_\_\_\_

### VEINS (VASCULAR)

Leg pain with walking/rest: Yes  No  Explain: \_\_\_\_\_

Blood clots in legs: Yes  No  Explain: \_\_\_\_\_

Aortic aneurysm: Yes  No  Explain: \_\_\_\_\_

Chronic leg ulcers: Yes  No  Explain: \_\_\_\_\_

Varicose veins: Yes  No  Explain: \_\_\_\_\_

### SOCIAL HISTORY

Single  Married  Divorced  Separated  Widowed

Do you live alone? Yes  No

Employed? Yes  No

If yes, occupation \_\_\_\_\_

If no, is it because of a back or neck problem? Yes  No

Date last worked \_\_\_\_\_

Do you have children? Yes  No

How often do you exercise? Never  Rarely  Weekly  Daily

What type of exercise? \_\_\_\_\_

Have you ever smoked/chewed tobacco? Yes  No

If yes, how recently? \_\_\_\_\_/how much? \_\_\_\_\_ pack(s) per day

How long have you smoked/chewed? \_\_\_\_\_

Have you recently stopped? Yes  No

If yes, when? \_\_\_\_\_

Do you drink alcohol? Yes  No

If yes, how much? \_\_\_\_\_

Have you ever been tested for HIV(AIDS)? Yes  No

If yes, what was the result? Positive  Negative

Do you have a history of substance abuse? Yes  No

If yes, what was the substance? \_\_\_\_\_

### FAMILY HISTORY

Do any of your grandparents, parents, siblings or children have any of the following diseases? Explain.

Diabetes: Yes  No  Explain: \_\_\_\_\_

High blood pressure: Yes  No  Explain: \_\_\_\_\_

Heart attack: Yes  No  Explain: \_\_\_\_\_

Cancer: Yes  No  Explain: \_\_\_\_\_

Arthritis: Yes  No  Explain: \_\_\_\_\_

Rheumatoid Arthritis: Yes  No  Explain: \_\_\_\_\_

Back or neck problems: Yes  No  Explain: \_\_\_\_\_

AIDS/HIV: Yes  No  Explain: \_\_\_\_\_

Bleeding disorders: Yes  No  Explain: \_\_\_\_\_

Epilepsy: Yes  No  Explain: \_\_\_\_\_

Hepatitis: Yes  No  Explain: \_\_\_\_\_

Migraines/headaches: Yes  No  Explain: \_\_\_\_\_

Psychiatric problems: Yes  No  Explain: \_\_\_\_\_

Stomach: Yes  No  Explain: \_\_\_\_\_

Thyroid problems: Yes  No  Explain: \_\_\_\_\_

I hereby authorize Borgess Health to examine and treat me or my dependent child and to perform such diagnostic tests and/or x-rays as may be necessary for the duration of treatment for this injury or illness. I hereby authorize the release of any medical information necessary to process my Medicare and/or insurance claims and for any benefits payable under my policy to be paid directly to Borgess Health. I understand this information may include information related to the diagnosis and/or treatment of alcohol/substance abuse, psychological/mental health disorders and/or HIV serostatus. I understand that I am responsible for payment of any charges incurred. I accept this responsibility regardless of any reimbursement or coverage. In the case of Medicare, I am responsible for payment of any charges not paid by Medicare.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_