Joseph A. Shehadi, M.D., L.L.C.
Neurosurgery Associates

☐ Columbus ☐ Marysville ☐ Dublin

Initial Medical History Form
(Bring this completed form to your office visit)

Name: _____ **Age:** _____

Which hand do you write with? _____

Have you ever been seen by Joseph A. Shehadi, M.D. before? Yes No

Have you ever been seen by Tiffany Epps, C.N.P. before? Yes No

How did you hear about us?
☐ Word of Mouth ☐ Internet ☐ Referred by a Doctor ☐Other_____

Referring Physician_____

Address_____Phone_____

Family Physician_____

Address_____Phone_____

Other physicians you see_____

Address_____Phone_____

Pharmacy _____Phone_____

How will your visit be handled financially?
☐ Ordinary Medical Insurance ☐ Workman's Comp (BWC) ☐ Personal Injury (lawyer)

** If personal injury, then please fill out a **separate additional form**, including name of law firm. See front desk.*

REASONS FOR THIS OFFICE VISIT

Pain: Where is your pain? _____

On a scale of 0-10, *(where 0 is no pain and 10 is the worst pain ever)*, please rate your pain:

Today: 0 1 2 3 4 5 6 7 8 9 10 **On average:** 0 1 2 3 4 5 6 7 8 9 10

How long have you had this pain? _____

What makes the pain better? (Check all that apply)

☐ Pain Pills ☐ Rest ☐ Leaning Forward ☐ Other _____

What makes the pain worse? (Check all that apply)

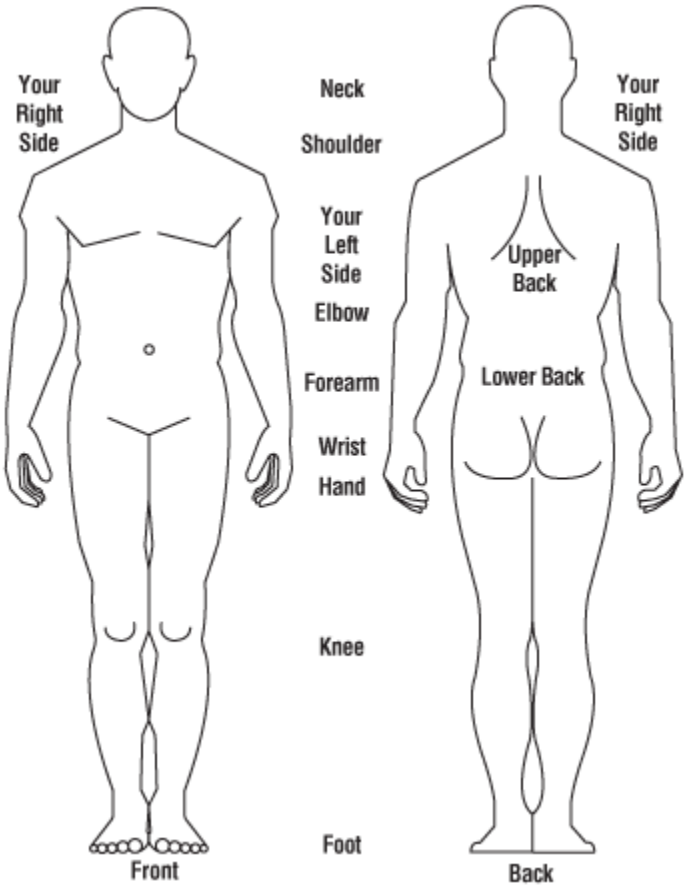
☐ Physical Activity ☐ Prolonged Sitting ☐ Prolonged Standing
☐ Coughing ☐ Sneezing ☐ Other _____

Any Numbness? **Y** **N**
If so, where is your numbness? _____

Any Muscle Weakness? **Y** **N**
If so, where is your weakness? _____

Any Incontinence? (accidents)
None **Bladder** **Bowel**

Significant Sexual Dysfunction? **Y** **N**



Please **SHADE** in area(s) where your **PAIN** is located and circle areas of **NUMBNESS**

How would you best describe your PAIN:

☐ Sharp (Nociceptive)
☐ Burning (Neuropathic)
☐ Both

Is your pain or numbness constant?
Y **N**

Neuroimaging Studies **Body part (ex. Neck, Back, etc.):**

☐ X-ray _____

☐ MRI _____

☐ CT scan _____

☐ EMG/NCS (nerve study) _____

☐ Other _____

Conservative treatments for this problem? (check all that apply)

☐ Medications ☐ Steroid Injections ☐ Physical Therapy ☐ Chiropractic care ☐ TENS Unit

☐ Other _____

Surgical Treatments (if any) for this problem?

_____

PAST MEDICAL HISTORY (e.g. diabetes, etc.)

_____

_____

_____

_____

CURRENT MEDICATIONS / SUPPLEMENTS	**Dose**	**Frequency**

Do you currently take ASPIRIN or products containing ASPIRIN? **Y** **N**

Do you take herbal supplements that may thin your blood (such as Ginseng)? **Y** **N**

ALLERGIES (to medications, latex, contrast dye, etc.) _____

_____

PAST SURGERIES / HOSPITALIZATIONS	**Year**	**Doctor**	**Complications**

FAMILY MEDICAL HISTORY

List any diseases that run in your family (such as Diabetes, High Blood Pressure, Aneurysms, Cancer, Brain Tumors, Headaches, etc.):

_____

_____

SOCIAL HISTORY

Occupation _____

Are you currently working? **Y** **N**

If not working, when was the last month and year you worked? _____

Current Employer _____

Are you on disability? **Y** **N**

If so, for what reason? _____

Tobacco:

☐ Yes, I smoke _____ packs of cigarettes per day and have for the past _____ years

☐ No, I have never smoked cigarettes

☐ No, I quit _____ years ago

Have you ever considered quitting smoking? **Y** **N**

Alcohol: How many alcoholic beverages do you consume per week? _____

Are you at risk for AIDS (e.g. previous blood transfusion, drug abuse, sexual history)?

☐ Yes ☐No If yes, please explain _____

Do you have any pacemakers or metal implants in your body? **Y** **N**

MISC: Is there any special information we should know about you that has not already been described (Examples: do you have a rare blood disorders, or Jehovah's Witness, etc.)

_____

_____

REVIEW OF SYMPTOMS

Have you **recently** had problems with any of the following:

Constitutional

☐ Fever
☐ Weight loss
☐ Excessive fatigue
☐ Night Sweats
☐ Loss of appetite

Eyes, Ear, Nose, Throat, Mouth

☐ Hearing loss
☐ Wear a hearing aid
☐ Ringing in ears
☐ Eye infections
☐ Eye injuries
☐ Glaucoma
☐ Cataracts
☐ Ear pain
☐ Ear infections
☐ Sore throats
☐ Mouth sores
☐ Balance disturbance (vertigo/spinning)
☐ Lightheadedness
☐ Nosebleeds
☐ Nasal congestion
☐ Nasal drainage
If yes, color _____ amount _____
☐ Inability to smell
☐ Sinus problems
☐ Sinus headaches

Musculoskeletal

☐ Broken bones
List _____
☐ Arm or leg weakness
☐ Back pain
☐ Arm or leg pain
☐ Joint pain or swelling
☐ Arthritis

Integumentary

☐ Skin cancer
☐ Breast pain tenderness, swelling
☐ Nipple discharge

Date and result of last mammogram

_____

Neurological

☐ Fainting spells
☐ Seizures
☐ Problems with your memory
☐ Disorientation
☐ Difficulty with your speech
☐ Inability to concentrate
☐ Double or blurred vision
☐ Face weakness
☐ Lack of coordination in arms/legs

Psychiatric

☐ Depression

Cardiovascular

☐ Chest pain or angina
If yes, date of last EKG

_____

☐ Palpitations
☐ Pacemaker
☐ Irregular pulse
☐ Heart murmur
☐ High cholesterol

Respiratory

☐ Asthma
☐ Chronic cough
☐ Emphysema
☐ Shortness of breath
☐ Bronchitis
☐ Pneumonia
☐ Lung cancer
☐ Bloody sputum
When? _____
☐ Last chest x-ray?

_____

Gastro-intestinal

☐ Indigestion or pain with eating
☐ Trouble swallowing
☐ Nausea
☐ Vomiting If yes, when? _____
☐ Blood in your vomit
☐ Liver problems
☐ Jaundice
☐ Abdominal pain
☐ Change in your bowel habits
☐ Ulcers or Gastritis

Genitourinary

☐ Urinary Tract infection
☐ Pain urination
☐ Blood in your urine
☐ Difficulty starting / stopping stream
☐ Incontinence
☐ Kidney stones
☐ Prostate cancer (males)
☐ Endometriosis (females)

☐ Anxiety
☐ Other psychiatric disorders / treatments

_____

Endocrine

☐ Diabetes
☐ Thyroid disease
☐ Increased appetite
☐ Excessive thirst or urination
☐ Hormone problems

Hermatologic / Lymphatic

☐ Anemia
☐ Hemophilia
☐ Bleeding tendencies
☐ Persistent swollen glands / lymph nodes
☐ Blood transfusion

Allergic/immunologic

☐ Food allergies If yes, list

_____

☐ Inhalant (nasal allergies)
☐ Immunologic disorders

☐ Uterine or cervical cancer (female)	

All the information provided above is accurate and complete to the best of my knowledge.

Patient Signature_____ Date _____

I have reviewed the above information with the patient

Physician's Signature _____ Date_____

Joseph A. Shehadi, M.D.
Neurosurgery Associates, L.L.C.
NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

The Notice of Privacy Practices tells you how we may use and share your health records. **Please read it.**

- We will use and share your health records to treat you and to bill for the services we provide
- We will not use your personal health information for services that you pay for privately
- We will use and share your health records to operate this medical practice
- We will use and share your health records as required by law

All the ways we may use and share your health records are explained in more detail in the **Notice of Privacy Practices.**

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy of your health records
2. You have the right to receive a list of whom we have given your health records to
3. You have the right to ask for us to correct a mistake in your health records
4. You have the right to ask that we not use or share your health records
5. You have the right to ask us to change the way we contact and communicate with you regarding your care and treatment

NOTE: All of these rights are explained in more detail in the **Notice of Privacy Practices**

I have received a copy of Neurosurgery Associates Notice of Privacy Practices

Signature: _____ Date: _____
(of patient or legal representative)

Capacity of Legal Representative (if applicable)*: _____

*May be requested to provide verification of representative status

CONSENT:

I consent to the use and sharing of my health records for treatment, payment, and operation purposes as described in the Notice of Privacy Practices. I know that if I do not consent, you cannot provide services to me.

Please be advised that the **information authorized for disclosure may include information which may be considered a communicable or venereal disease, including but not limited**

to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). It also may include mental health or other sensitive information.

Signature: _____ Date: _____
(of patient or legal representative)

Capacity of Legal Representative (if applicable)*: _____

*May be requested to provide verification of representative status

Joseph A. Shehadi, M. D., Neurosurgery Associates
Financial Policy

Your clear understanding of our **financial policy** is important to our professional relationship. Please understand that payment of your bills is considered part of your overall treatment in our office. In order to keep your cost of healthcare to a minimum, the following financial policies have been adopted for use here at the ***Neurosurgery Associates, L.L.C.***

Acknowledging with your signature below, you understand and accept the following:

Required at Check-In

Each time you check in for your appointment you will be required to:

1. Verify Personal Demographic and Contact Information
2. Present Current Copy of **Insurance Card**
3. Pay any Outstanding Account Balance
4. Pay your **Insurance Co-Pay** for Current Visit

Fees for Administrative Services and Penalties

- **Missed Appointment:** Missed appointments cancelled with less than 24 hour notice or "no show." **$25.00** ***per occurrence.***
- **Form Completion Charge**: **$20.00** for each ***initial form***; **$10.00** for ***renewal forms*** These forms: FMLA, Short-term Disability and Long-term Disability
- **Returned Check Fee: $30.00** ***per check*** will be assessed on your account.
- **All outstanding balances must be paid in full within 30 days of receiving your bill or before your next visit with Neurosurgery Associates** unless other arrangements have been made with the Billing Manager. Outstanding balances are subject to a **$10.00** ***late fee*** for each 30-day cycle past due.
- **Collection Charges:** Accounts that are not paid in a reasonable amount of time may be sent to an external collection agency and reported to the credit bureau, and are subject to ***additional charges*** imposed by the agency.

I understand and agree to abide by the above policies and procedures as outlined in ***Joseph A. Shehadi, M. D., Neurosurgery Associates, LLC, Financial Policy***.

Print Name: _____ **Date:** _____

Patient Signature: _____ **Date:** _____