Saint Luke's
MARION BLOCH
NEUROSCIENCE INSTITUTE

Saint Luke's Neurological Consultants
A division of Saint Luke's Marion Bloch Neuroscience Institute
Office number: 816-960-7600
Fax number: 816-960-7699

Dear New Patient:

Welcome to our practice! We are committed to providing you the best possible care. Enclosed in this policy letter is information that will assist us in your care.

Office Policy: The Physician you are scheduled to see will be the Physician you see while you are treated by our clinic. ***Please be prepared for the appointment, by bringing a list of questions/concerns and bringing a current list of Medications.*** You may bring family member(s) or a caretaker with you. While our Physicians make every effort to be prompt, please understand that he/she may be behind schedule due to emergencies and complex patient care issues. ***You may fax this packet back to 816-960-7600 prior to your appointment or bring it with you at the time of your appointment.*** This will expedite your care. You will receive an automated reminder call prior to your appointment. If you are unable to keep your appointment, please call us as soon as possible to ensure another patient has the opportunity for an appointment. It is also the patient's responsibility to ensure medical records from your physician(s) have been received by our office prior to your appointment.

Insurance policy: Our office staff works with many different insurance companies, as well as many types of insurance. It is the patient's responsibility to verify the physician participation, ensure the proper referrals and pre-certifications are done with your specific insurance company, prior to your appointment. Please bring all insurance cards to all appointments. Your co-payment is due when you sign in upon arrival. Our office accepts checks, cash, Mastercard and Visa. There is a $30.00 fee for any check returned non-paid.

OUR OFFICE DOES NOT ACCEPT WORK COMP, MOTOR VEHICLE OR INJURY CASES

If you have any questions about our office practice or policy, please feel free to call our office to discuss your concerns. By signing below, I, the patient, agree to the policy detailed above.

____ ____________________________
Signature Date

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NAME: **DATE OF BIRTH:** **TODAY'S DATE:**

Relationship	Name	Address	Phone #	Fax #
Primary care physician (PCP)				
Pharmacy				
Provider who asked you to see a neurologist (if not your PCP)				

REASON FOR YOUR VISIT? (list diagnosis and/or describe your symptoms and how long you have had them):

Current pain level (circle):

0 (no pain)	2 (little bit of pain)	4 (more painful)	6 (very painful)	8 (extremely painful)	10 (worst pain of life)

Where does it hurt? ____

Is the pain changing? (circle): getting better staying the same getting worse

PLEASE LIST YOUR MEDICAL CONDITIONS ("PAST MEDICAL HISTORY"):

Disease/Condition	**When were you diagnosed?**

PLEASE LIST SURGERIES YOU HAVE HAD ("PAST SURGICAL HISTORY"):

Surgery	Date of surgery

PLEASE INDICATE (CIRCLE OR CHECK BOX) ANY OTHER MEDICAL ISSUES YOU HAVE THAT PERTAIN TO TODAY'S VISIT:

GENERAL
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Breast cancer
- ☐ Broken bones
- ☐ Depression
- ☐ Fatigue
- ☐ Fever
- ☐ Sweats
- ☐ Weakness
- ☐ Weight gain
- ☐ Weight loss

SKIN
- ☐ Bleeding skin lesions
- ☐ Blistering
- ☐ Birth mark
- ☐ Burns
- ☐ Chronic rash
- ☐ Dark pigmented skin lesions
- ☐ Excessive sun exposure
- ☐ Family member with nevus syndrome
- ☐ Melanoma
- ☐ Psoriasis
- ☐ Skin Cancer
- ☐ Vitiligo

MOUTH/NECK
- ☐ Dental problems
- ☐ Hoarseness
- ☐ Laryngitis
- ☐ Swollen glands
- ☐ Wear dentures

EYES/EARS/NOSE
- ☐ Cataracts
- ☐ Eye problems
- ☐ Glaucoma
- ☐ Loss of hearing
- ☐ Loss of vision
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus trouble
- ☐ Low vision (wear glasses or contacts)

HEART/BLOOD/VESSELS
- ☐ Chest pain (angina)
- ☐ Congenital heart disease
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Leg cramps at night
- ☐ Leg cramps when walking
- ☐ Rapid heartbeat (that required treatment)
- ☐ Rheumatic fever
- ☐ Short of breath at night
- ☐ Swollen ankles

ENDOCRINE/GLANDS
- ☐ Diabetes mellitus
- ☐ Thyroid disease
- ☐ Hypothyroidism
- ☐ Thyroid cancer

LUNGS
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Cough every day
- ☐ Cough produce sputum
- ☐ Blood in sputum
- ☐ Emphysema
- ☐ Frequent colds
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Short of breath at rest
- ☐ Short of breath with activity
- ☐ Tuberculosis

NEUROLOGICAL
- ☐ Arthritis
- ☐ Back pain
- ☐ Blackouts
- ☐ Confusion
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Double vision
- ☐ Epilepsy / seizure(s)
- ☐ Fibromyalgia
- ☐ Forgetfulness
- ☐ Hallucinations
- ☐ Headaches / Migraines
- ☐ Memory problems
- ☐ Numbness
- ☐ Stroke / TIA
- ☐ Swollen joints
- ☐ Weakness of arm(s)
- ☐ Weakness of leg(s)
- ☐ Vision changes

GASTROINTESTINAL
- ☐ Black bowel movements
- ☐ Bloody bowel movements
- ☐ Cirrhosis
- ☐ Colon cancer
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excess saliva
- ☐ Gall bladder problems
- ☐ GERD / reflux
- ☐ Heartburn
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Jaundice (yellow skin)
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Difficulty swallowing
- ☐ Ulcers / gastritis
- ☐ Upset stomach
- ☐ Other intestinal problems

GENITOURINARY
- ☐ Prostate cancer
- ☐ Difficulty urinating
- ☐ Sexual dysfunction

OTHER

PLEASE LIST YOUR MEDICATIONS:

Medication Name	Dose (MG) (milligrams)	# of pills for each dose	# of times taken per day	Check if only taken when needed

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PLEASE LIST YOUR MEDICATION ALLERGIES:

Medication Name	Reaction

PLEASE INDICATE YOUR FAMILY HISTORY OF MEDICAL CONDITIONS (add family members to the list as needed):

Relationship	Is this person alive?	Dementia or Alzheimer's	Headaches or migraines	Multiple sclerosis	Neuropathy	Parkinson's disease	Tremors	Cancer (what type?)	Cerebral aneurysm	Diabetes	High cholesterol	High blood pressure	Seizures or epilepsy	Stroke or TIA	Mental illness	Other
Mother																
Father																

PLACE ANY ADDITIONAL FAMILY HISTORY INFORMATION HERE:

PLEASE INDICATE IF YOU USE ANY OF THESE:

	Currently using?	Amount per day	Start date	Quit date	Interested in quitting?
Coffee	Yes / No				
Tea	Yes / No				
Soda pop	Yes / No				
Cigarettes	Yes / No				
Cigars	Yes / No				
Chewing tobacco	Yes / No				
Wine	Yes / No				
Beer	Yes / No				
Liquor	Yes / No				
Marijuana	Yes / No				
Cocaine	Yes / No				
Methamphetamines	Yes / No				
Heroin	Yes / No				
Other					

TELL US ABOUT YOURSELF:

Are you currently working? If so, where do you work and what do you do?	
How far did you go in school (highest grade completed)?	
How many children do you have?	
Are you single, married, divorced, or widowed?	