

**LUCIA ZAMORANO, MD, PLC
NEUROLOGICAL SURGERY**

REGISTRATION DATA & INSURANCE INFORMATION

(Please Print)

Date: _____ Account # _____

Patient Name _____ Married () Single ()

Date of Birth _____ Home Phone: _____

Home Address _____ City/State. _____ Zip Code. _____

Social Security # _____ Driver's License # _____

Employer _____ Employment Phone: _____

Emergency Contact:

Name: _____ Phone: _____

INSURANCE INFORMATION

Subscriber: _____ Insurance Co: _____

Contract #: _____ Group #: _____ Subscriber's DOB: _____

Date Of Visit _____

LUCIA ZAMORANO, MD, PLC
NEUROLOGICAL SURGERY
Health History Questionnaire

- Complete as best you can. Doing so now will save 30-45 minutes at your appointment-

Personal Information

Your Last Name _____ First Name _____ Middle Initial _____ Age _____

Street Address/Apt. No. _____ City _____ (State _____ Zip _____

Home Phone () _____ Work Phone () _____ Cell/Mobile Phone () _____

Social Security Number: _____ Date of Birth: _____ E-mail Address _____

Emergency Contact Information

Contact's Last Name _____ First Name _____ Middle initial _____ Relationship _____

Street Address/Apt. No. _____ City _____ State _____ Zip _____

Home Phone () _____ Work/Cell Phone () _____ E-mail Address _____

How were you referred?

() Physician () Self/Other

If referred by physician, date referred _____

Physician Information

Physician's Last Name _____ First Name _____ Middle Initial _____

Street Address/Suite _____ City _____ State _____ Zip _____

Office Phone () _____ Fax: () _____ E-mail Address _____

LUCIA ZAMORANO, MD, PLC
NEUROLOGICAL SURGERY

Do you have a primary care physician?.....() Yes () No

Physician's Last Name	First Name	Middle Initial
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Street Address/Suite _____ City _____ State _____ Zip _____

Office Phone () _____ Fax() _____ E-mail Address _____

Does your insurance require referrals for office visits and/or tests?..... () Yes () No

List all other physicians who should receive results of your consultation

Physician's Last Name	First Name	Middle Initial
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Street Address/Suite _____ City _____ State _____ Zip _____

Office Phone _____ Fax _____ E-mail Address _____

Physician's Last Name	First Name	Middle Initial
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Street Address/Suite _____ City _____ State _____ Zip _____

Office Phone _____ Fax _____ E-mail Address _____

Physician's Last Name	First Name	Middle Initial
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Street Address/Suite _____ City _____ State _____ Zip _____

Office Phone _____ Fax _____ E-mail Address _____

Surgery

Have you ever had cancer surgery? If "yes," describe below.....()Yes () No

Month/Year of Surgery	Area of Body Treated	Hospital	Physician

Describe any problem(s) you experienced during or after surgery:

Radiation Therapy

Have you ever had radiation therapy? If "yes," describe below.....() Yes () No

Start Date - End Date	Area of Body Treated	Hospital	Physician

Describe any problem(s) you experienced during or after radiation therapy:

Chemotherapy

Have you ever had chemotherapy? If "yes," describe below.....() Yes () No

Start Date ~ End Date	Chemotherapy Drug/Regimen	Hospital	Physician
-			
.			
-			
-			

Describe any problem(s) you experienced during or after chemotherapy:

Medical History: Noncancer

How was your health before your diagnosis?..... () Excellent () Good () Fair () Poor
 How do you feel right now?.....() Excellent () Good () Fair () Poor

Medical Illnesses or Conditions: List all noncancer illnesses or conditions (for example, diabetes, heart disease, high blood pressure) starting with most recent.

Illness/Condition	Date Diagnosed	Treatment	Physician

Hospitalizations & Operations: List all noncancer hospitalizations and operations starting with most recent.

Reason for Hospitalization	Date(s) Hospitalized	Hospital	Physician

Medications: List all medications you are now taking (including vitamins and nonprescription drugs) and doses starting with most recent. **Bring all medications to your first visit.**

Medication	Date Prescribed	Dosage	Frequency

Medical Allergies

	Yes	No	Don't Know
Are you allergic to the dye used in X-rays?			
Are you allergic to latex?			
Are you allergic to medications (for example, Penicillin)?			

Medication	Date of Reaction	Type of Allergic Reaction

Social History	Yes	No	Don't Know
Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Number of dependents at home:			
Education: <input type="checkbox"/> Grade school <input type="checkbox"/> High school <input type="checkbox"/> College <input type="checkbox"/> Other:			
Main language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Arabic <input type="checkbox"/> Other:			
Need a translator?			
Have reliable transportation to medical appointments?			
Have insurance coverage for prescription drugs?			
Have advanced directive/durable power of attorney? (If "yes," bring to appointment,)			
Have family/friends to help you during your treatment?			
Have emotional support from family members/friends?			
Have someone living with you?			
If "yes," name: _____ Phone: () _____			
Need help coping with your diagnosis?			
If "yes," are you receiving help?			
If "yes," name: _____ Location: _____			
Does your family need help coping with your diagnosis?			
Are you currently being abused physically, sexually or emotionally?			
Would you like to speak with a cancer counselor?			
Occupation/Work History & Environmental Exposure	Yes	No	Don't Know
What is your current occupation?			
Did you previously have a different occupation?			
Were you ever exposed to the following (work or elsewhere):			
Asbestos			
Chronic Fumes			
Chronic Dust			
Radiation			
Toxic Chemicals			
Other (list)			
Tobacco, Alcohol & Other Substance Use	Yes	No	Don't Know
Do you use? <input type="checkbox"/> Cigarettes <input type="checkbox"/> cigars <input type="checkbox"/> pipe <input type="checkbox"/> chewing tobacco <input type="checkbox"/> snuff <i>{check all that apply}</i>			
How much do you use per day? _____ Number of years? _____			
Did you use?. <input type="checkbox"/> cigarettes <input type="checkbox"/> cigars <input type="checkbox"/> pipe <input type="checkbox"/> chewing tobacco <input type="checkbox"/> snuff <i>(check all that apply)</i>			
How much did you use per day? _____ Number of years? _____ When did you stop? _____			
Have you been exposed to secondhand smoke at home or work?			
Do you drink alcoholic beverages regularly?			
Do you drink alcoholic beverages on social occasions, only?			
Has alcohol ever interfered with your personal/professional life?			
Did you, or do you, use marijuana?			
Have you have used cocaine, heroin or other illegal substances?			

Review of Systems

If you are currently experiencing — or previously experienced — any of the following to a significant degree, explain on the back of this page.

General	Yes	No	Don't Know
Fever			
Sweats			
Weakness			
Fatigue			
Weight Loss			
Pain	Level		
Average pain most days:	0 1 2 3 4 5 6 7 8 9 10 (none/low) (worst)		
Where does it hurt?			
Staying the same or « getting worse?	()Same()Worse		
What are you taking for it?			
Does this help?			
Skin	Yes	No	Don't Know
Excessive sun exposure			
Blistering/burns			
Use sunscreen			
Dark or pigmented skin lesion			
Dark or pigmented skin lesion removed			
Melanoma			
Bleeding skin lesion			
Skin cancer			
Psoriasis			
Chronic rash			
Vitiligo			
Birthmark			
Family member with dysplastic nevus syndrome			

Eyes	Yes	No	Don't Know
Lost vision			
Wear glasses Cataracts			
Glaucoma			
Ears	Yes	No	Don't Know
Lost hearing			
ringing in your ears			
Sinuses	Yes	No	Don't Know
Sinus trouble			
Nosebleeds			
Mouth	Yes	No	Don't Know
Dental problems			
Wear dentures			
Sore tongue			
Neck	Yes	No	Don't Know
Swollen glands			
Laryngitis			
Hoarseness			
Breast	Yes	No	Don't Know
Breast biopsy			
Breast cancer			
Nipple discharge			
Breast lumps			
Cystic breast disease			
Breast infection			
Mammogram			
Hormone replacement therapy			
Breastfed any children			
If "yes/' how long in total months:			

Lungs	Yes	No	Don't Know
Cough every day			
Cough, produce sputum (phlegm) most days			
Blood in your sputum			
Pneumonia			
Bronchitis			
Emphysema			
Pleurisy			
Tuberculosis			
Asthma			
Short of breath with activity			
Short of breath at rest			
Frequent colds			
Heart, Blood Vessels	Yes	No	Don't Know
Chest pain (Angina)			
Chest pressure			
Heart attack			
Short of breath at night			
Heart murmur			
Rapid heartbeat that required treatment			
Swollen ankles			
Leg cramps at night			
Leg cramps when walking			
Rheumatic fever			
Congenital heart disease			

Gastrointestinal	Yes	No	Don't Know
Lost appetite			
Recent weight change			
If yes, amount:	Loss	C	Pain
Excess saliva			
Swallowing problems			
Difficult			
If yes, date started:			
Solids stick			
If yes, where:			
Pain			
If yes, date started:			
Choking			
Food comes out your nose			
Heartburn			
Ulcer			
Endoscopy (upper GI, colonoscopy, etc*)			
Nausea			
Vomiting			
Vomit blood			
Diarrhea			
Upset stomach (food related)			
Constipation			
Black bowel movements			
Bloody bowel movements			
Yellow or jaundiced			
Hepatitis			
Gall bladder problems			
Cirrhosis			

Genitourinary	Yes	No	Don't Know
Kidney problems			
Frequent urination			
Painful urination			
Urinate at night			
Blood in urine			
Kidney stones			
Genitourinary: Men	Yes	No	Don't Know
Difficulty starting/ stopping urination			
Sexual performance problems			
Elevated prostate blood test (PSA)			
Prostate biopsy			
Swollen/painful testicle			
Genitourinary: Women	Yes	No	Don't Know
Age started menstruating:			
Irregular or painful menstruation			
Still menstruating			
Date of last menstrual period:			
Age stopped menstruating:			
Painful intercourse			
Bleeding following intercourse			
Endome trios is			
Did your mother take estrogens when pregnant with you?			
Date of your last pap smear:			
Pregnant now			
Number of pregnancies:			
Number of children: Number of miscarriages:			
Age at first pregnancy:			

Neurological	Yes	No	Don't Know
Dominant hand: __ Right ___ Left			
Headaches			
Seizure			
Double vision			
Blurred vision			
Weakness in extremity			
Numbness			
Stroke			
Migraine headaches			
Forgetfulness			
Confusion			
Hematologic	Yes	No	Don't Know
Blood transfusion			
Rejected as blood donor			
Bruise or bleed easily			
Anemic			
Take aspirin or nonsteroid anti-inflammatory (Motrin, Advil, Alleve)			
Swollen glands			
Extremities & Back	Yes	No	Don't Know
Arthritis			
Back pain			
Broken bone			
Swollen joints			
Endocrine/Glands	Yes	No	Don't Know
Diabetes mellitus			
Thyroid disease			
Other endocrine/gland conditions (list)			

Additional questions you have:

Physician Reviewer _____

Date _____

LUCIA ZAMORANO, MD, PLC

NEUROLOGICAL SURGERY

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION AND CONSENT TO INFORMATION IN ELECTRONIC FORM

1. Referring Physician:

Name: _____

Address: _____

City/State/Zip: _____

Phone#: _____

2. Primary Care Physician:

Name: _____

Address: _____

City/State/Zip: _____

Phone#: _____

3. Automobile Accident (if FULL Auto):

Agency: _____

Address: _____

City/State/Zip: _____

Phone#: _____

4. Workers Compensation:

Agency: _____

Address: _____

City/State/Zip: _____

Phone#: _____

5. ___ I give the doctor permission to speak to the following family member and/or friend:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

6. ___ I give the doctor permission to release all medical information and records to:

Name: _____ Relationship/Agency: _____

Name: _____ Relationship/Agency: _____

7. ___ I do not wish to have information released to anyone at this time.

I have reviewed the above information and verify that it is correct.

Patient Printed Name _____ Date _____

Patient Signature _____ Date _____

This is a confidential professional and private document of Lucia Zamorano, MD, PLC. Unauthorized disclosure or duplication of this consent is absolutely prohibited.

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NEUROLOGICAL SURGERY

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	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
<u>Initials</u>															
Height															
Weight															
Blood Pressure															
Pulse															
Temperature															
Respiratory Rate															
Poise Oximetry															
Pain VAS (0-10)	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Fatigue Score(0-10)															
Sleeping Problems															
Concerns															
Appetite Change															
Port/CVC															
Recent tests/procedures															
New medications															
New allergies															
Change in Primary MD															
Performance status															

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**LUCIA ZAMORANO, MD, PLC
NEUROLOGICAL SURGERY**

		Date	Date	Date	Date	Date	Date	Date	Date
MEDICATION	Dose/Frequency								

ALLERGIES

Date	Allergen	Reaction

IMMUNIZATIONS	Date	Date	Date

