BOULDER MEDICAL CENTER, P.C.

Dear Patient,

Attached you will find a new patient questionnaire. Please fill this out with as much information as possible and bring it with you to your appointment. I have found that going through the questionnaire ahead of time often helps to jog people's memories about details of their history. If you have records from a previous neurologist, please contact their office to request that they be faxed to our office, ahead of your appointment. ***Fax:(303)440·3209.***

Please also request reports and discs of any pictures you have had of your brain or your spine, such as MRIs and CT scans, especially if they were done recently, or if they were ordered for the specific problem for which I am seeing you. Be aware it may take several weeks for other providers to send us your records.

Please remember to bring your insurance card and ID with you to your appointment. Also, it is important that you either list your medications on the questionnaire, or bring a list of medications, including dosages and when you take the medication, or bring your medication bottles to your appointment.

Please arrive at least **15 minutes before your appointment time** to park and complete the necessary paperwork at the Reception Desk. Your time is valuable to me. Although in medicine there are often emergencies that result in delays in the schedule that are beyond my control, I make every effort to keep your wait time as short as possible. If you are more than 5 minutes late for your appointment, you will be asked to reschedule for another day.

Your new patient paperwork and records will be reviewed at your New Patient appointment ONLY but NOT before then.

Thank you for your cooperation in this so that we can make the most of your visit. I look forward to meeting you. If you have any further questions please contact my Medical Assistant at 303-440-3134.

To schedule an appointment, please call 303-440-3134.

Sincerely,

Paula Mendes, M.D.

BOULDER MEDICAL CENTER, P.C.

Department of Neurology

New Patient Questionnaire

Your new patient paperwork and records will be reviewed at your New Patient appointment ONLY but NOT before then..

Please complete the form below with as much information as possible and bring it with you to your first appointment.

Name:____

Dominate Hand: Right______ Left ______

Today's Date:____________________ Date of Birth________________

Name of referring doctor___________________________

Please briefly describe the reason for your appointment

____

____

____

____

____

Please list the main questions you would like me to answer

____

____

____

____

____

Have you been seen by another neurologist in the past? YES* NO

*If yes: Name of Doctor:__________________________________Date: __________

Have you had any pictures (X-ray, CT, MRI) of your brain or spine, or neurologic testing (EEG, EMG, neuropsych testing)? YES* NO

*If yes, please list the type of test, date it was done, and facility where it was performed.

____

____

____

____

*Please request that copies of records and test results be sent to our office prior to your appointment. Fax: (303) 440-3209. (It may 10-12 days for records to be received.)

Medications:

Please list the medications you are taking, including the dose, and when you take them. Please include over the counter medications and supplements (If you already have a list, you may bring it with you for us to copy)

____

____

____

____

____

____

Medical history:

Have you ever been diagnosed with:			Age/Date at Onset
Alcoholism	YES	NO	________
Arthritis	YES	NO	________
Asthma/COPD	YES	NO	________
Cancer	YES	NO	________
Dementia/Alzheimer's	YES	NO	________
Depression/Anxiety	YES	NO	________
Diabetes	YES	NO	________
Fibromyalgia	YES	NO	________
Heart disease	YES	NO	________
High Blood Pressure	YES	NO	________
Kidney Disease	YES	NO	________
Liver Disease	YES	NO	________
Multiple Sclerosis	YES	NO	________
Parkinson's Disease	YES	NO	________
Post-traumatic Stress Disorder (PTSD)	YES	NO	________
Psychiatric illness	YES	NO	________
Stroke/TIA	YES	NO	________
Thyroid disease	YES	NO	________

Surgical History: Please list any surgeries you have had:

____
____
____
____
____

Social history:

Have you ever smoked? YES* NO
*If Yes- How much?_____________________
For how long? _________
Do you smoke now (tobacco or marijuana)? YES* NO
*If Yes- How much?_____________________
For how long? _________
Do you drink alcohol? YES NO
How many drinks per week?________
Do you use any other non-prescription drugs? YES NO
Do you work outside the home? YES NO
What do you do?__________________
Are you retired? YES NO
What did you previously do?_____________
Education Level:____
Civil State: Circle One Single Married Divorced Partnered Widowed
Living Situation: Circle all that apply
I live alone I live with Friends I live with Family
I live independently I live in assisted living I live in a nursing home

Family history:
Has anyone in your family (parents, siblings, and children) been diagnosed with:

Aneurysm	YES	NO
Dementia/Alzheimer's	YES	NO
Diabetes	YES	NO
Multiple Sclerosis	YES	NO
Muscle/Nerve Disorder	YES	NO
Parkinson's Disease	YES	NO
Seizures	YES	NO
Stroke	YES	NO
Other Neurologic conditions	*YES	NO

* If yes please explain:

BOULDER MEDICAL CENTER, P.C. REVIEW OF SYSTEMS

Patient Name:____ Date of Birth:____________________________
Please Print

Why are you seeing the Provider today?____

____

Tobacco Status and Usage	Quantity / Frequency	Alcohol Usage	Quantity / Frequency	Caffeine Usage	Quantity / Frequency
O Current every day smoker		O Yes		O Yes	
O Current some day smoker		O Never	NA	O No	NA
O Former smoker	NA	O Former		**Exercise**	Frequency
O Never smoked	NA			O Yes	
				O No	NA

Please mark with an "X" any symptoms you are currently experiencing

Constitutional
_____ Fatigue
_____ Fever
_____ Night Sweats
_____ Weight Gain
_____ Weight Loss

HEENT
_____ Ear Pain
_____ Hearing Loss
_____ Sinus Pressure/Problems
_____ Visual Changes
_____ Ringing in the ears
_____ Double Vision (Diplopia)*
_____ Facial Pain*
_____ Snoring*
_____ Pain with chewing*
_____ Excessive sleepiness*

Respiratory
_____ Cough
_____ Shortness of breath
_____ Wheezing
_____ Regurgitation

Cardiovascular
_____ Chest pain
_____ Swelling in legs or arms (edema)
_____ Palpitations
_____ Hypertension

Gastrointestinal
_____ Blood in stools
_____ Constipation
_____ Diarrhea
_____ Heartburn
_____ Vomiting
_____ Ulcers
_____ Difficulty swallowing (Dysphagia)*

_____ **Genitourinary**
_____ Blood in the urine (Hematuria)
_____ Frequent urination
_____ Difficulty in urination

Reproductive
_____ Menstrual disorders
_____ Prostate problems

Integumentary
_____ Rash

Neurological
_____ Dizziness
_____ Extremity numbness
_____ Extremity weakness
_____ Balance problems
_____ Headaches
_____ Seizures
_____ Head injury
_____ Strokes*

Psychiatric
_____ Anxiety
_____ Depression
_____ Insomnia

Metabolic / Endocrine
_____ Cold Intolerance
_____ Heat intolerance
_____ Diabetes
_____ Thyroid imbalance*

Musculoskeletal
_____ Joint pain
_____ Joint swelling
_____ Neck pain
_____ Muscle pain

_____ **Hematologic/Lymphatic**
_____ Easy bleeding
_____ Easy bruising
_____ Lumps in the neck

Immunologic
_____ HIV infection of AIDS

BOULDER MEDICAL CENTER, P.C. - PROTECTED HEALTH INFORMATION MANAGEMENT FORM

PLEASE PRINT

Patient Name:________________________________ Medical Record #______________________________

Date of Birth:_________________________________ Date of Request:________________________

As allowed by Privacy Regulations, I wish for this office to record the following changes regarding my Protected Health Information. This request remains current until a new written request is submitted.

Access to Medical Records

☐ The following individuals may have access to this medical record (listed above) and may speak on my behalf:

Name	DOB	Relationship	Phone #

☐ Other Instructions____

____

Denial of access to Medical Records

☐ The following individuals are denied access to this medical record (listed above) and may not speak on my behalf:

Name	DOB	Relationship	Phone #

☐ Other Instructions____

____

The Boulder Medical Center has the right to deny any of these requests. If that is determined to be necessary, an authorized representative will notify you in writing within 30 days of this request.

____ ____________________

Signature of Patient or Authorized Patient Representative Date

____

Printed name of staff verifying the above information is correct and legible

Original of this form must be submitted to Release of Records at Broadway within 3 business days of request.
Release of Records will update your medical records within 7 business days of request.
This form will be scanned into your Medical Record and then will be destroyed.

RPP001a Rev4/20