# 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 Registration 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.

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 303-440-3216.

***To schedule an appointment, please call 303-440-3216.***

Sincerely,

Paula Mendes, M.D.

# BOULDER MEDICAL CENTER, P.C.

Department of Neurology

New Patient Questionnaire

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 Rev04/19