

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Previous or referring doctor:		

PERSONAL HEALTH HISTORY

Childhood illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio	
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

Reason you are being treated today:

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Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Please turn to next page

Neurological Center of NOVA

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Email: _____

Work Phone: (____) _____ - _____ ext _____

Cell Phone: (____) _____ - _____

Social Security Number: _____ - _____ - _____ Sex: Male Female

Marital Status: Single Married Divorced Widowed

Date of Birth: ____/____/____

Employment Status: Full-time Part-time Retired

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Student Status: Full-time Part-time

RESPONSIBLE PARTY INFORMATION

If the patient is the person responsible for paying any out of pocket expense, please mark "self" and turn over to sign the Assignment and Release statement.

Patient's relationship to the responsible party: Self Spouse Child

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Work Phone: (____) _____ - _____ ext _____

Social Security Number: _____ - _____ - _____ Sex: Male Female

Date of Birth: ____/____/____

Employment Status: Full-time Retired

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med <input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med <input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea <input type="checkbox"/> Cola
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you considered stopping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever experienced blackouts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you prone to "binge" drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you drive after drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times ____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I authorize payment directly to Samad Oraee, M.D., PC of any medical/surgical benefits otherwise payable to me by my insurance carrier for services as described. Also, I hereby authorize the release of any information obtained in the course of my registration, interview, examination and treatment, necessary to file a claim with my insurance carrier(s) or deemed necessary pursuant to State or Federal law, statute or regulation.

NON-COVERED SERVICES

I accept responsibility for paying any monies not paid by my insurance carrier for a balance due, except that dollar amount which is limited by agreement between Samad Oraee, M.D., PC and the insurance carrier. Furthermore, I acknowledge that it is my responsibility to obtain any necessary healthcare care service plan authorizations/referrals before my visit takes place. Moreover, I agree that it my responsibility to contact my insurance carrier to confirm if Samad Oraee, M.D., PC is in my network and/or plan, before my visit takes place.

PRACTICE FINANCIAL POLICIES

I recognize that payment for all co-pays, deductibles, co-insurances and other pre-determined out of pocket expenses are expected at time of service. I acknowledge that it is my responsibility to know the amount of my out-of-pocket expenses and I agree to check with my insurance carrier before each visit to confirm any changes. I recognize that Samad Oraee, M.D., PC reserves the right to charge me for missed appointments and will bill my account for finance charges at the rate of 1.5% per month on my balance(s) after a period of 60days from the date of service. In the event that my account is placed in the hands of a collection agency or attorney for collection, I agree to pay all costs and expenses related to the collection thereof. A copy of my signature consenting to this agreement is as valid as the original, and shall continue to be valid for one year from the date of signature.

Patient/Responsible Party Signature

_____/_____/_____
Date of Signature

**AUTHORIZATION FOR RELEASE
OF CONFIDENTIAL HEALTH CARE INFORMATION**

Patient Name:	Date of Birth:	
Street Address:		
City:	State:	Zip:

This authorizes Dr.Samad Oraee to request and receive from the
Prescriber's Name
Virginia Department of Health Professions any and all records held by the Department relating to Schedule II-V controlled substances dispensed to the patient names above.

I understand that this authorization permits the Department of Health Professions to disclose confidential health care records to the prescriber named above. A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by law.

I understand that, if not previously revoked, this consent will expire one year after the date of my signature unless otherwise specified.

Patient Signature:	Date:
Guardian Signature:	Date:

NOTE: This authorization form is in addition to and separate from any other disclosure forms that you may have signed.

Neurological Center of Northern Virginia

Sam Oraee, M.D., Neurology and Pain management

Deborah Williams, RN, MSN, APRN, CNRN

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MISSED APPOINTMENT POLICY

Dear Patient;

In an effort to serve you better and improve quality and efficiency we ask you to keep your scheduled appointments. In the event of an emergency or if you are unable to keep your scheduled appointment time, please call our office at least 24 hours in advance. All no shows and cancelled appointment outside of courtesy call period will be assessed a fee. This fee is not covered by insurance and will be your responsibility.

***New and follow up visit-\$35 if not cancelled within 24 hours**

***NCS/EMG-\$100 if not cancelled within 48 hours.**

***EEG/Video EEG-\$100 if not cancelled within 48 hours.**

Thank you for your cooperation.

Sam Oraee, MD

Deborah William, APRN

Staff

Date: _____ Signature: _____