Neurology South, P.C.
R. Kolanu, M.D.
Patient Information Sheet

Patient Name____ SS#________________

Street Address____ Apt.#_________

City, State, ZIP_________________________________ Home Phone____________

Sex M / F Cell Phone _______________ Work Phone____________

E mail __________________________ Employer ____________________________

Date of Birth__________________ Age____ Marital Status S M D W O

Spouse's Name____________________________________ Work Phone____________

Nearest Relative Not Living With You____________________________________

Phone Number__________________________

Nearest Friend Not Living With You______________________________________

Phone Number__________________________

Physician_______________________________________ Phone___________________

Whom may we contact in case of an emergency?____________________________

Phone Number__________________________

Whom may we thank for referring you to us?______________________________

Phone Number__________________________

Person (not Ins. Co.) Responsible For This Bill_________________________

I will be paying today by Cash____ Check #________ Other______________

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature____ Date_______________

Parent (if minor)___________________________________ Date_______________

Insurance Information

Insured's Name________________________________ Insured's SS#____________

Relationship to Patient________________ Insured's Date of Birth________

Street Address____

Insured's Employer______________________ Insurance Name_________________

Secondary Insurance___________________________ Insured's SS#____________

CLINICAL INFORMATION

NAME : ____________________ DATE OF BIRTH : ____________________

1. What is your reason for seeing Dr. Kolanu?

____

2. How long have you had this problem? If related to injury, please give date of injury and state if work-related.

____

3. Other medical history? Circle all that apply.

Diabetes High Blood Pressure Heart Disease Cancer Emphysema Stroke Seizures Any other medical conditions ____________________

4. Past surgeries, if any? ____________________

5. Current medications ____________________

____

6. Allergies to medications ____________________

7. Address and phone number of your regular pharmacy ____________________

____

8. Do you smoke and if so, how much? __________ Quit date, if applicable __________

9. Do you drink any alcohol and if so how much? ____________________

10. Do any other members of your family have similar medical conditions? If so, please specify.

____

11. Any other relevant information? ____________________

SIGNATURE : ____________________ TODAY'S DATE : ____________________

REVIEW OF SYSTEMS

Please check if you have/had problems related to the areas indicated.

	YES	NO
1. **CONSTITUTIONAL**		
Weight change	❑	❑
Fevers	❑	❑
Sweats	❑	❑
Fatigue	❑	❑
2. **EYES**		
Glaucoma	❑	❑
Cataracts	❑	❑
Vision surgery	❑	❑
3. **EARS, NOSE, THROAT**		
Loss of hearing	❑	❑
Dizziness	❑	❑
Nose bleeding	❑	❑
Gum bleeding	❑	❑
4. **RESPIRATORY**		
Chronic cough	❑	❑
Bronchitis	❑	❑
Shortness of breath	❑	❑
Asthma	❑	❑
Pneumonia	❑	❑
5. **CARDIOVASCULAR**		
Heart attack	❑	❑
Chest pain/angina	❑	❑
Heart murmur	❑	❑
Anemia	❑	❑
Transfusions	❑	❑
Phlebitis or blood clots	❑	❑
Rheumatic fever	❑	❑
6. **GASTROINTESTINAL**		
Reflux	❑	❑
Hepatitis A	❑	❑
Blood in stools	❑	❑
Diarrhea/constipation	❑	❑
Hernia/repair	❑	❑
Gall bladder disease	❑	❑

	YES	NO
7. **ENDOCRINE SYSTEM**		
Diabetes	❑	❑
Thyroid problem	❑	❑
Hormone treatment	❑	❑
Anabolic steroids	❑	❑
8. **BREAST/GENITAL**		
Menopause	❑	❑
Masses	❑	❑
Genital infections	❑	❑
9. **URINARY SYSTEM**		
Urinary tract/bladder infections	❑	❑
Kidney stones	❑	❑
Incontinence	❑	❑
Trouble urinating	❑	❑
Prostate problems	❑	❑
10. **SKIN**		
Cancers	❑	❑
Rashes	❑	❑
11. **NEUROLOGIC**		
Stroke	❑	❑
Seizures	❑	❑
Head injury	❑	❑
Nerve damage	❑	❑
12. **PSYCHIATRIC**		
Depression	❑	❑
Anxiety	❑	❑
13. **MUSCULOSKELETAL**		
Osteoarthritis	❑	❑
Rheumatoid arthritis	❑	❑
Gout	❑	❑

OTHER_________________________________

____

____

____

____

The information provided in this form is true and complete to the best of my knowledge.

Patient signature____

Updated (date)______________________ ________________________ _______________________

___________________________________ ________________________ _______________________

*Form reviewed by physician:*_____________________

*Date:*_____________________