2841 Debarr Road, Suite 32, Anchorage, AK 99508 Tel. 907.331.3640
3831 Piper Street, Suite SLL020, Anchorage, AK, 99508 Fax: 907.331.3647

Please bring completed forms to your office visit or fax them to (907) 331-3647. Thank you

PATIENT INFORMATION

Name: _____ Today's Date: _____

Date of Birth: _____ SSN: _____

Mailing Address: _____ Unit / Apt #: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ home / mobile / work E-mail: _____

Language:_____ Race:_____Ethnicity:_____

Emergency Contact Person (not living with you): _____

Relationship: _____ Phone Number: _____

Pharmacy Name: _____ Phone Number: _____

INSURANCE INFORMATION

Primary Insurance Coverage: _____

Claims Mailing Address: _____

Insurance Company Phone: _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder Date of Birth: _____

Policy Holder's SSN#: _____ Relationship to Patient: _____

Secondary Insurance Coverage: _____

Claims Mailing Address: _____

Insurance Company Phone: _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder Date of Birth: _____

Policy Holder's SSN#: _____ Relationship to Patient: _____

You can access our patient portal at www.peakneurology.com and gain full access to your medical history. You can also message your provider, request prescription refills, update your personal information, and receive a care summary after your visit.

PAST MEDICAL HISTORY INTAKE

Who referred you to our office? _____

Who is your Primary Care Physician? (If different than referring provider)_____

Chief complaint (why are you here today?) _____

Have you or has any family member experienced any of the following? Please **check** the appropriate box:

	Self	Mother	Father	Sister	Brother
Diabetes					
High blood pressure					
Kidney or bladder disorder					
Asthma					
COPD					
Chronic pain					
Heart disease, heart surgeries, or other heart problems (like congestive heart failure, A-Fib, or heart attack)					
Stroke or warning stroke					
Substance Abuse					
Sleep Apnea					
Depression / Mental Illness					
Acid reflux					
Other					
Age at Death					

List all other medical conditions_____

_____

_____

MAJOR HOSPITALIZATIONS

Year	Operation or Illness	Name of Hospital	City and State

Allergies to Medications: Please list each allergy and the reaction you had to that medicine.

1)_____ 2) _____

3)_____ 4) _____

LIST OF CURRENT MEDICATIONS:

Do you take prescription narcotic medication for pain? This includes narcotic pain medications like Vicodin, Percocet, and Oxycontin. Please list all prescription pain medications below, even if you only take them occasionally.

Name of Medication	Strength	How many do you take, and how often do you take?

List all other tablets, patches, drops, ointments, injections, etc. Include prescription, over the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin). You may choose to attach a separate list, if necessary.

Name of Medication	Strength	How many do you take, and how often do you take?

SOCIAL HISTORY

Occupation: _____ Marital status (circle one): Single Married Divorced Widowed

How many children do you have, and how old are they? _____

Do you consume alcohol? Yes / no If yes, write type and amount per week: _____

Do you smoke? Yes / no If yes, write type and amount per day: _____

Do you chew tobacco? Yes / no If yes, write frequency _____

Do you exercise? Yes / no If yes, write type and frequency: _____

Do you consume caffeine (including caffeinated beverages such as energy drinks, coffee, tea, or cola)? If yes, write type and frequency _____

What time do you usually eat your last meal of the day? _____

REVIEW OF SYSTEMS

Constitutional ☐ normal ☐ undernourished ☐ fever ☐ chills ☐ recent weight change	**Musculoskeletal** ☐ normal ☐ weakness ☐ cramps ☐ joint stiffness/swelling ☐ joint/back pain
Eyes ☐ normal ☐ blindness ☐ corrective lenses ☐ blurred or double vision ☐ dry eyes	**Integumentary (skin)** ☐ normal ☐ dry ☐ rash ☐ change in color/texture ☐ varicose veins
Ears/Nose/Throat ☐ normal ☐ hearing loss ☐ nosebleed ☐ hoarseness ☐ swollen neck glands ☐ chronic nasal congestion	**Allergic/Immunologic** ☐ no known allergies ☐ food allergy ☐ medication allergy ☐ immune deficiency
Cardiovascular ☐ normal ☐ chest pain ☐ palpitation ☐ irregular rhythm ☐ swelling of extremities ☐ high blood pressure ☐ congestive heart failure	**Endocrine** ☐ normal ☐ excessive thirst ☐ diabetes ☐ excessive hunger ☐ heat/cold intolerance ☐ known glandular/hormone issues
Respiratory ☐ normal ☐ chronic cough ☐ COPD ☐ asthma ☐ short of breath ☐ wheezing ☐ TB	**Hematological/Lymph** ☐ normal ☐ anemia ☐ easy bleeding/bruising ☐ swollen lymph nodes
Gastro-Intestinal ☐ normal ☐ nausea ☐ vomiting ☐ abdominal pain ☐ diarrhea ☐ constipation ☐ rectal bleeding ☐ difficulty swallowing ☐ jaundice ☐ heartburn	**Neurological** ☐ normal ☐ dizziness ☐ stroke ☐ syncope ☐ frequent headache ☐ migraines ☐ seizures ☐ numbness ☐ paralysis ☐ tremors
Genito-Urinary ☐ normal ☐ pain with urination ☐ urgency ☐ blood in urine ☐ incontinence/dribbling ☐ testicle pain ☐ menstrual pain	**Psychological** ☐ normal ☐ depression ☐ anxiety ☐ insomnia ☐ memory loss/confusion ☐ dementia ☐ drug/alcohol abuse

SLEEP QUESTIONS

On weekdays, I usually go to sleep at _____ and wake at _____.

On weekends, I usually go to sleep at _____ and wake at _____.

On average it takes me _____ minutes to fall asleep.

I need ____ hours of sleep to feel rested in the morning.

How many times (on average) do you usually get up to urinate during the night? _____

Do you snore or have you been told that you snore? Yes / no

Do you feel sleepy during the daytime? Yes / no

Do you feel like your sleep is “restful” such that you feel restored in the morning? Yes / no

Please **check** the appropriate box:
What is your weight now? _____ Lbs. 1 year ago? _____ Lbs. 5 years ago? _____ Lbs.

	Never	Rarely	Occasionally	Frequently
Have you ever been told you stop breathing in your sleep?				
Does chest pain or shortness of breath disturb your sleep?				
How often do you wake up choking or gasping for air?				
Do you ever wake up with headaches?				
Do you ever wake up with acid heartburn or a sour taste?				
Do you ever wake up with a dry mouth?				
Does restlessness in your legs ever prevent you from sleeping?				
Do your legs ever twitch or kick while you sleep?				
Do you ever act out your dreams (while sleeping)?				
Do you ever feel paralyzed upon waking from sleep?				
Do you ever experience vivid dreams in naps?				
Do you ever get weak or wobbly knees during extreme anger, hard laughing, or while surprised?				
Do you ever grind your teeth at night?				
Do you ever have visual or auditory hallucinations while sleeping?				
Do you take sleeping pills or alcohol in order to sleep?				

What is your height? _____ Ft. _____ in.

What is your shirt collar size? _____ In.

What size pants do you wear (waist)? _____ In.

NAPPING AND DROWSINESS

How many purposeful naps do you take a day? _____ During a typical week? _____

How often do you accidentally doze off during an average day? _____ Week? _____

Do you have difficulty focusing or concentrating in the daytime? Yes / no

In the last 3 years, have you caused an accident by falling asleep when driving? Yes / no

DROWSINESS RATING SCALE

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how these activities would have affected you.

Use the following scale and indicate your chances of dozing:

(0) Never doze (**1)** Slight chance of dozing (**2)** Moderate chance of dozing (**3)** High chance of dozing

	Rating
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g., a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
EDSS Total	

FOSQ-10 (Functional Outcomes of Sleep Quality)

Q1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q2. Do you generally have difficulty remembering things because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q4. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q5. Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q6. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q7. Do you have difficulty watching a movie or video because you become sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q8. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q9. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q10. Has your mood been affected because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

I verify that the above information is true and accurate to the best of my knowledge.

X_____ _____

Signature of patient (or parent if patient is a minor) Date