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

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