PEAK NEUROLOGY
AND SLEEP MEDICINE, LLC

New Patient Intake Paperwork

Today's date: _____

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call (907) 331-3640 if you have any questions or are unsure how to complete any section of this form. You can fax this paperwork ahead of time to (907) 331-3647.

Your name: _____ Gender: ☐ Male ☐ Female

Date of birth: _____ Social security number: _____

Mailing address: _____ City/State/Zip: _____

Phone: _____ ☐ Home ☐ Mobile ☐ Work Email: _____

Language: _____ Ethnicity: _____

Emergency contact: _____ Relationship: _____

Phone: _____

Insurance information

Primary insurance coverage: _____

Policy number: _____ Group number: _____

Policy holder name: _____ Policy holder DOB: _____

Policy holder SSN: _____ Relationship to patient: _____

Secondary insurance coverage: _____

Policy number: _____ Group number: _____

Policy holder name: _____ Policy holder DOB: _____

Policy holder SSN: _____ Relationship to patient: _____

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

Patient intake

Who referred you to our office? _____

Why were you referred to our office? _____

Who is your **primary care physician**? (if different than referring provider) _____

Are there **any other providers** of which you are currently a patient? (Please list all) _____

_____

Medical history

Have you ever experienced any of the following? Please check the appropriate boxes:

- ☐ Anxiety
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic pain
- ☐ COPD
- ☐ Dementia/memory loss
- ☐ Depression
- ☐ Diabetes
- ☐ Headaches
- ☐ Migraines
- ☐ Heart attack
- ☐ Heart disease
- ☐ Atrial fibrillation
- ☐ Congestive heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney/bladder disease
- ☐ Multiple sclerosis
- ☐ Myasthenia gravis
- ☐ Obstructive sleep apnea
- ☐ Parkinson's disease
- ☐ Peripheral neuropathy
- ☐ PTSD
- ☐ Reflux disease
- ☐ Seizure/epilepsy
- ☐ Stroke
- ☐ Substace abuse
- ☐ Head injury
- ☐ Tremor
- ☐ Dizziness/vertigo

Please list any other medical problems:

Family medical history

Please list the living status, age, medical problems, and/or cause of death for applicable family members.

Family member	Living status	Age, now or at a death	Medical problems	Cause of death
Mother	☐ Living ☐ Deceased			
Father	☐ Living ☐ Deceased			
Sibling ☐ M ☐ F	☐ Living ☐ Deceased			
Sibling ☐ M ☐ F	☐ Living ☐ Deceased			
Sibling ☐ M ☐ F	☐ Living ☐ Deceased			

Surgical and major hospitalization history

Please list all past surgical operations and/or major hospitalizations by date, operation/illness, and where they occurred.

Date	Operation/Illness	Name of hospital and/or surgeon	City and state

Social history

Substance	Currently use?	Previously used?	Type	Amount
Tobacco	☐ Yes ☐ No	☐ Yes ☐ No		_____ per day
Alcohol	☐ Yes ☐ No	☐ Yes ☐ No		_____ drinks per week
Caffiene	☐ Yes ☐ No	☐ Yes ☐ No		_____ drinks per day

Have you ever drank alcohol heavily **in the past?** If yes, please list type/amount, and date of discontinuation:

Current occupation: _____ Previous occupation: _____

Marital status (circle one): ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

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

Do you exercise? ☐ Yes ☐ No If yes, write type and frequency: _____

Medication list

Please list all current medications, including medications taken on an as needed basis and supplements/other over the counter medications.

Medication name	Strength/Dose	How many do you take, and how often?

Medication allergies

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

Medication name	Reaction

Review of Systems

Please check any that you have experienced within the last 6 months.

Consitutional

- [ ] Mal-nourished
- [ ] Fever
- [ ] Chills
- [ ] Recent weight change

Eyes

- [ ] Blurred vision
- [ ] Double vision
- [ ] Blindness
- [ ] Corrective lenses
- [ ] Dry eyes

Ears/Nose/Throat

- [ ] Hearing loss
- [ ] Hoarseness
- [ ] Nosebleeds
- [ ] Swollen neck glands
- [ ] Chronic nasal congestion

Cardiovascular

- [ ] Chest pain
- [ ] Irregular rhythm
- [ ] Palpitations
- [ ] Swelling of extremities
- [ ] High blood pressure

Respiratory

- [ ] Chronic cough
- [ ] Wheezing
- [ ] Shortness of breath
- [ ] COPD
- [ ] Asthma
- [ ] Tuberculosis

Gastrointestinal

- [ ] Abdominal pain
- [ ] Nausea
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Rectal bleeding
- [ ] Difficulty swallowing
- [ ] Jaundice
- [ ] Heartburn

Genitourinary

- [ ] Blood in the urine
- [ ] Pain with urination
- [ ] Voiding urgency
- [ ] Pelvic pain
- [ ] Bedwetting
- [ ] Menstrual pain
- [ ] Testicular pain
- [ ] Bladder incontinence

Musculoskeletal

- [ ] Joint stiffness
- [ ] Joint swelling
- [ ] Muscle cramps
- [ ] Back pain
- [ ] Joint pain

Integumentary (skin)

- [ ] Rash
- [ ] Change in skin color
- [ ] Varicose veins

Allergic/immunologic

- [ ] Food allergy
- [ ] Medication allergy
- [ ] Immune deficiency

Endocrine

- [ ] Excessive thirst
- [ ] Temperature-intolerance
- [ ] Diabetes
- [ ] Excessive hunger
- [ ] Hormone deficiency

Hematological/Lymph

- [ ] Anemia
- [ ] Easy bruising/bleeding
- [ ] Swollen lymph nodes

Neurological

- [ ] Weakness
- [ ] Memory lapses or loss
- [ ] Dementia
- [ ] Numbness
- [ ] Headache
- [ ] Dizziness
- [ ] Stroke
- [ ] Seizures
- [ ] Fainting (syncope)
- [ ] Migraines
- [ ] Tremor

Psychological

- [ ] Depression
- [ ] Anxiety
- [ ] Insomnia
- [ ] Substance abuse

Sleep questionnaire

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.

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

Do you feel like your sleep is "restful" such that you feel restored in the morning? **Yes / No**

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

In the last 3 years, have you caused an accident by falling asleep while driving? **Yes / No**

Please check the appropriate boxes:	**Never**	**Rarely**	**Occasionally**	**Frequently**
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 kick or twitch while you are asleep?				
Do you ever act out your dreams while asleep?				
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 suprised?				
Do you ever grind your teeth at night?				
Do you ever have visual or auditory hallucinations while falling asleep or waking up?				
Do you ever take sleeping pills or alcohol in order to sleep?				

Drowsiness rating scale (please indicate chance of falling asleep with the given options)
(0) Never doze (1) Slight chance of dozing (2) Moderate chance of dozing (3) High chance of dozing

Sitting and reading	
Watching TV	
Sitting, intactive in a public place (e.g. 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: _____