Advanced Neurology
OF COLORADO

2121 East Harmony Road, Suite 180
Fort Collins, CO 80525
Phone: 970-226-6111 / Fax: 970-226-6707
Tamara Miller, M.D.
Jerry Nash, M.D.
Jill Olson, M.D.

Thank you for selecting our practice. In order to better serve your needs, please complete the included new patient paperwork and BRING IT WITH YOU TO YOUR APPOINTMENT**.** In addition, please remember to bring the following items with you:

- Insurance Card
- Driver's License or other form of photo identification
- Your co-payment if required by your insurance
- A copy of any reports, x-rays, discs or films

*****PLEASE ARRIVE 30 MINUTES EARLY FOR YOUR SCHEDULED APPOINTMENT*****

Name:_____ Date of Birth:_____

Social Security#:_____ Sex: M / F Age:_____

Marital Status: _____

Address:_____ City, State, Zip:_____

Email Address:_____

Consent to receive e-mail communication? Yes / No

Phone 1:_____ Phone 2:_____

Emergency Contact:_____ Relationship:_____

Emergency Phone#:_____

Referring Physician:_____ Primary Physician:_____

Insurance Provider:_____ Effective Date (Month & Year):_____

Insurance ID#:_____ Group ID#:_____

Employer Name: _____

Subscriber Information (Who is main subscriber of the insurance if different than patient)

Name:_____ Date of Birth:_____

Social Security#:_____ Phone: _____

Secondary Insurance: _____ Effective Date (Month & Year):_____

Insurance ID#:_____ Group ID#:_____

Employer Name: _____

Patient Name _____
(Please Print)

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE

Please list the reason for your visit and describe your symptoms: _____

_____

_____

_____

How long has this condition existed? _____

ALLERGIES

Do you have any allergies to medications? Yes / No
If yes, please list: _____

_____

_____

_____

TOBACCO HISTORY

Do you use tobacco? Yes / No
If yes, list amounts: Packs per day _____ Years _____
Have you ever used tobacco? Yes / No When ? _____

PAST MEDICAL HISTORY

Have you had similar problems/symptoms in the past? Yes / No
If yes, please explain: _____

_____

_____

_____

_____

SURGICAL HISTORY

Please list any operations and/or medical problems you have had in the past (include dates):

_____

_____

_____

Patient Name _____
(Please Print)

FAMILY MEDICAL HISTORY

Do you have any family members that have ever had any of the following conditions?
If yes, please specify family member and check maternal or paternal where applicable:

		Family Member	Maternal	Paternal
Hypertension	Yes / No			
Neuropathy	Yes / No			
Seizures	Yes / No			
Headaches	Yes / No			
Diabetes	Yes / No			
Bleeding Problems	Yes / No			
Heart Disease	Yes / No			
Psychiatric Problems	Yes / No			
Cancer	Yes / No			
Multiple Sclerosis	Yes / No			
Stroke	Yes / No			
Tremor	Yes / No			

SOCIAL HISTORY

Do you consume alcoholic beverages? Yes / No

If yes, what type? _____ For how long? _____

Daily / Weekly amount: _____

Do you use recreational drugs? Yes / No

If yes, what type? _____ For how long? _____

Daily / Weekly amount: _____

PHARMACY INFORMATION

Your preferred **LOCAL RETAIL** Pharmacy (Name & Address): _____

_____

Your preferred **MAIL ORDER** Pharmacy (Name & Address): _____

_____

Patient Name _____
(Please Print)

MEDICATIONS

Please include ALL medications including over the counter medications:

Are you taking any medications at this time? Yes / No

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Medication: _____ _____MG # per day_____

Reason for taking: _____

Patient Name _____
(Please Print)

FALL SCREENING

Falls within last 3 months? Yes / No

Fear of falling? Yes / No

Difficulty Ambulating? Yes / No

REVIEW OF SYMPTOMS

Are you right or left hand dominant? Right / Left

Do you have any problems with the following: If yes, please circle which symptom if applicable

General:	Fever Chills Weight Loss Weight Gain
Head:	Hearing Loss Ear Pain Sore Throat Tinnitus
Eyes:	Pain Redness
Lungs:	Cough Shortness of Breath Wheezing
Heart:	Chest Pain Palpitations Leg Swelling
Stomach:	Abdominal Pain Blood in Stools
Urinary:	Pain with Urination Incontinence
Muscles:	Muscle Pain
Skin:	Rash Itching Skin Wounds
Endocrine/Blood:	Bruise Easily Bleed Easily Deepening of the Voice
Psychiatric/ Behavioral:	Depression Suicidal Ideas Nervous/Anxiety
	Personality Changes Emotional Problems

Other: _____

_____

_____

_____ _____

Patient Signature **Date**

/rev 10.21.15 tb