Adult Neurology
290 St. Charles Way
York, PA 17402
717.851.5503 Tel
717.851.5507 Fax
800.864.4016 Toll Free
www.wellspan.org

Thank you for choosing WellSpan Neurology. We have prepared the following guidelines in an effort to ensure that we provide healthcare services to you in a highly efficient manner. Our physicians and staff look forward to assisting you with your healthcare needs.

- Always be on time, allowing 30 minutes for paperwork for initial appointments.
- A fee may apply if visits are not canceled 24 hours prior to your appointment. It is your responsibility to let us know in advance. We reserve the right to discharge you from our practice after the second no show/late cancellation for follow up patients and after the first no show/late cancellation for new patients. Please be aware that any cancellations made less than 24 hours prior to your appt will be considered a no show.
- If your insurance requires a referral to see a specialist, it is your responsibility to bring the referral with you to your appointment, without the referral you will need to reschedule your appointment.
- Bring in all insurance cards at every visit. You will be asked to show your card at every appointment.
- There is a charge of $15 for any forms that need to be completed by the physician for disability, insurance, or medical leave. Payment is required prior to the form being returned.
- All prescription refills should be handled through the pharmacy where the original prescription was filled.
- **Bring any results from tests performed outside of the WellSpan system such as MRIs, x-rays, blood tests and any other tests, medical records and medications with you to your first appointment.** It is also suggest that you bring all your medications in their bottles to every visit.
- Our office billing is provided by Physician Billing Services. If you have any questions regarding your bill, please call (717)851-6816.
- If you would like to learn more about our practice and WellSpan Health, please visit our website at www.wellspan.org.

Directions:
From Route 83 South
Exit 16A; South Queen Street to first light, make a right onto St. Charles Way; approximately ¼ mile on left side of road, FIRST single story building. Look for blue and yellow WellSpan sign; office is the first set of doors on building.

Patient Signature	DOB	Date
______________________________	____________	____________

WELLSPAN NEUROLOGY

COMPREHENSIVE MEDICAL HISTORY QUESTIONNAIRE

Patient Information:

Last Name:______________________________ First________________________ Middle___________

Age: _______ DOB: _____ / _______ / _______ Social Security Number:________ - _______ - __________

Address:____

City _____________________________ State_________________ ZIP ________________________

Home Number:_____________________Cell Phone: ___________________Work Phone:___________

Sex: M / F Marital Status:___________

Are we able to leave a message on your answering machine to verify appointments, to report normal test results, or to request a return phone call? Yes / No

Pharmacy Name: _______________________________ **Phone#:** _____________________

Pharmacy Address: ____

I: MEDICAL HISTORY

Please **CIRCLE** any illness or medical problems that you are currently being treated for:

Anemia	Drug Abuse	Headache/Migraine	Memory Loss	Seizure(s)
Alcohol abuse	Encephalitis	Hearing difficulty	Meningitis: Viral/Bacterial	Sexually Transmitted Disease
Blood Disorder	Fainting Spells	Kidney Disorder	Multiple Sclerosis	Staring Spells
Cerebral Palsy	Genetic Disorder	Liver Disorder	Osteoporosis	Speech/Language Problems
High Cholesterol	Head Injury	Lung Disorder	Parkinson's Disease	Stroke/ TIA's
Diabetes	Heart Disorder/Disease	Mental Retardation	Psychological Problems	High blood pressure
B12 Deficiency	Fibromyalgia	Sleep Apnea	Celiac Disease	Sjogren's Syndrome
Lyme Disease	Factor V	Anxiety	Lupus	Spinal Stenosis
OTHER:				

II: CURRENT ALLERGIES: Please list any medications you are allergic to and your reaction to them:

____

____

____

____

III: HOSPITALIZATIONS OR SURGERIES Please list any surgeries in the past:

____
____
____

IV: FAMILY HISTORY

Please check if any of the following diseases run in your immediate family and if so state which relative.

__Depression ____________________
__Diabetes ______________________
__Peripheral Neuropathy ___________
__Headache _____________________
__Hypertension __________________
__MS___________________________
__Memory Loss/Dementia__________
__Heart Disease__________________
__Muscle Weakness ____________________
__Myopathy______________________________
__Parkinson's___________________________
__Seizure _______________________________
__Stroke ________________________________
__Tremor ________________________________
__any type of Cancer ____________________
__High Cholesterol_______________________

V: SOCIAL HISTORY AND PRESENT LIVING SITUATION

1. Highest education level completed: grade school / middle school / high school / college
2. Whom do you live with?____

3. Do you work now? ❒ No If no, did you ever work? Yes / No
❒ Yes _____________ How many hours/week _________________________
What do you do at work? ____
4. Smoking History
______Presently smokes ________ppd __________ Never smoked
______Ex smoker Quit date____________

5. Alcohol History
___Presently drinks-please state approximately how much a week__________
a) Ever felt the need to cut down on your drinking? Yes / No
b) Ever felt annoyed by criticism of your drinking? Yes / No
c) Ever felt guilty about drinking? Yes / No
d) Ever take a morning drink? Yes / No
__Never drank alcohol

6. Do you use street drugs? ❒ No ❒ Yes

7. Do you drink beverages containing caffeine? ❒ No ❒ Yes, # of cups per day: ______________

8. Do you drive? ❒ Yes ❒ No If no, have you ever driven? Yes / No

VI. Please list the name(s) of the doctor(s) you would like us to communicate your results.

____

____

Please list all current medications below.

CURRENT MEDICATIONS			
Drug Name: Indicate Generic or Brand name, mg, and dosage	Times Given Be specific: AM/PM	Drug Name: Indicate Generic or Brand name, mg, and dosage	Times Given Be specific: AM/PM .

If you have a copy of your medications already prepared please give to staff at check in.