THE METROPOLITAN NEUROSURGERY GROUP

PATIENT REGISTRATION

Today's Date:_____/_____/_____	Primary Care Physician: _____ PCP Address: _____ _____ PCP Phone:_____

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI		
_____	_____	____	□ Mr. □ Mrs. □ Miss □ Ms.	□ Single □ Married □ Widow □ Divorce / Separate

DATE OF BIRTH	GENDER:	ETHNICITY (OPTIONAL)
_____/_____/_____	□ M □ F	□ White □ African American □ Hispanic □ Asian □ Native American □ Other

ADDRESS

P.O. BOX:_____ or:
STREET ADDRESS:_____
CITY:_____STATE:_____ZIP:_____

SOCIAL SECURITY NO:	OCCUPATION:
_____-_____-_____	

HOME PHONE:	CELLULAR:	EMAIL:

Who referred you to us?	Who is your geneticist?	Send letter (visit note) to?

Preferred Pharmacy Name and Address:	Pharmacy phone no:

Height:	**Weight:**	**BP** (leave for staff):	**HR** (leave for staff):
_____’_____”	_____**lbs.**	_____ /_____	_____ **/** min

List the 3 top concerns that you would like to discuss today:

1_____
_____
2_____
_____
3_____
_____

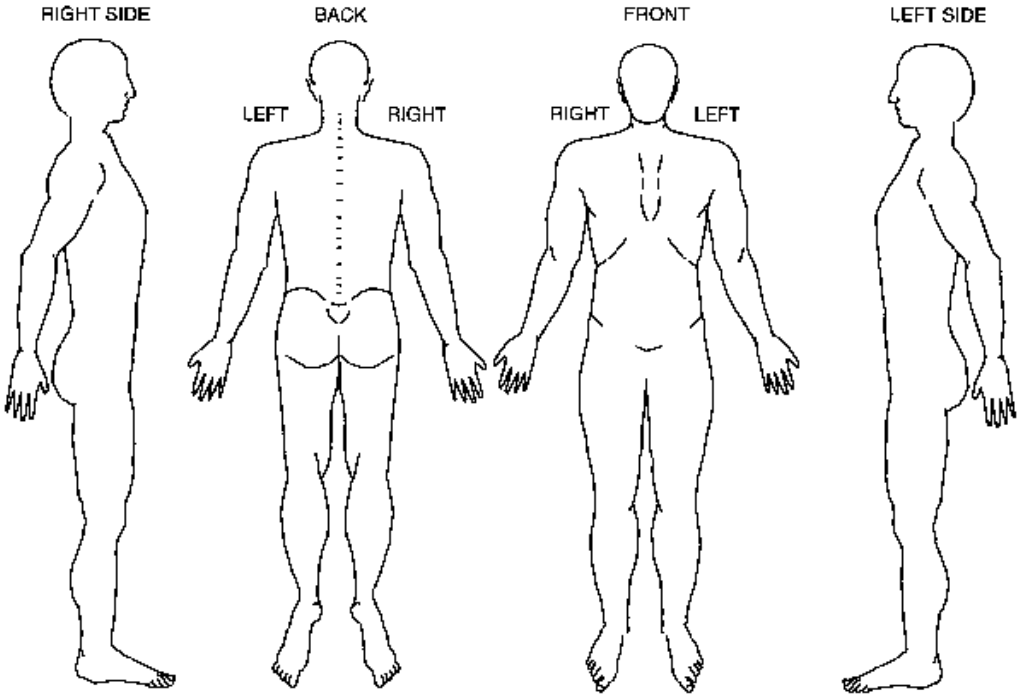
Imaging, tests or reports brought for review today:

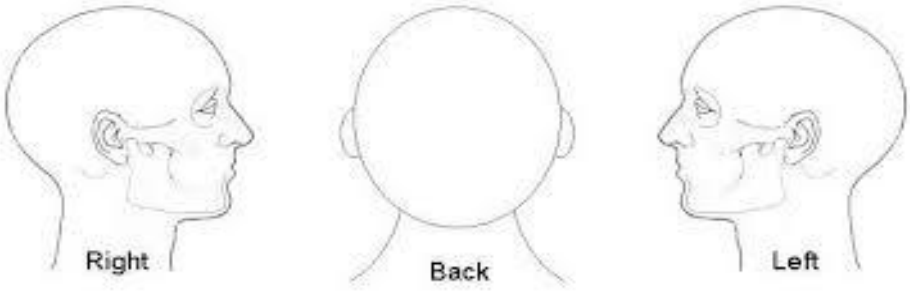
1_____**2**_____
3_____**4**_____
5_____**6**_____

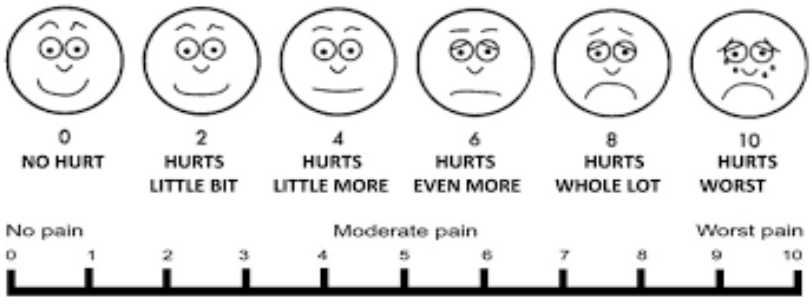
Patient Name:_____ **Date:_____**

PAIN ASSESSMENT:

Using the diagrams below, please indicate pain location, type, frequency and intensity.







PAIN TYPE:

+ aching **↓↓pins and needles**

♯ numb **● dull/throb**

▼ sharp **≈ nerve pain**

FREQUENCY

© continuous

≠ on and off

Patient Name:_____ **Date:**_____

PLEASE LIST ANY CONSERVATIVE TREATMENTS THAT YOU HAVE TRIED SO FAR:

PHYSICAL THERAPY:
Length of treatment and frequency:_____
Does your physical therapist specialize in EDS/Hypermobility?_____
Describe your response to treatment:_____
_____
_____

OCCUPATIONAL THERAPY:
Length of treatment and frequency:_____
Does your therapist specialize in EDS/Hypermobility?_____
Describe your response to treatment:_____
_____
_____

OTHER TYPES OF THERAPY (aqua, massage, dry needling, acupuncture, etc):
Type of procedure/treatment:_____
Length of treatment and frequency:_____
Does your therapist specialize in EDS/Hypermobility?_____
Describe your response to treatment:_____
_____
_____

NERVE BLOCKS AND EPIDURAL INJECTIONS: Date(s):_____
Type of block/injection_____
Describe your response to treatment:_____
_____
_____

OTHER PROCEDURES/TREATMENTS (BACLOFEN PUMP, TENS UNIT, etc.):
Type of procedure/treatment:_____
Length of treatment and frequency:_____
Describe your response to treatment:_____
_____
_____

BRACES: Type of brace:_____
Length of treatment and frequency:_____
Describe your response to treatment:_____
_____
_____

OTHER PROCEDURES, TREATMENTS OR MEDS (e.g. medications you have tried in the past for related symptoms, such as neurogenic bladder, chronic constipation/gastroparesis, nausea, POTS, etc).
_____
_____
Length of treatment and frequency:_____
Describe your response to treatment: _____
_____

Patient Name:_____ **Date:**_____

PLEASE LIST ALL MEDICATIONS THAT YOU HAVE TRIED FOR PAIN SO FAR:

NARCOTIC PAIN MEDICATIONS (e.g.: Oxycodone, Oxycontin, Dilaudid, Morphine Sulfate, Fentanyl patches, Percocet, Methadone, Marinol, etc) :

Drug			
Dose			
Frequency			
Length of treatment			
Response to treatment			
Are you still taking it?	**Yes No**	**Yes No**	**Yes No**

ORAL CORTICOSTEROIDS (e.g.: Medrol, Solucortef, Cortisone, Prednisone, Prednisolone, Methylprednisolone, Decadron, etc)

Drug			
Dose			
Frequency			
Length of treatment			
Response to treatment			
Are you still taking it?	**Yes No**	**Yes No**	**Yes No**

N.S.A.I.D.S (e.g.: Aspirin [Bufferin, Bayer, and Excedrin], Ibuprofen [Advil, Motrin, Nuprin], Ketoprofen [Actron, Orudis], Naproxen [Aleve], Daypro, Indocin, Lodine, Naprosyn, Relafen, Vimovo, Voltaren, Celebrex, Ketorolac, etc)

Drug			
Dose			
Frequency			
Length of treatment			
Response to treatment			
Are you still taking it?	**Yes No**	**Yes No**	**Yes No**

OTHER PAIN MEDICATIONS (e.g.: pain creams, lidocaine patches, Tylenol, etc)

Drug			
Dose			
Frequency			
Length of treatment			
Response to treatment			
Are you still taking it?	**Yes No**	**Yes No**	**Yes No**

Patient Name:_____ **Date:**_____

OTHER MEDICATIONS (please print)

Nr.	Medication	Dose	Frequency	Prescribing Physician	Taking since (year)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					

ALLERGIES

Nr.	Allergen	Reaction	Mild	Moderate	Severe
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Patient Name:_____ Date:_____

HISTORY

Social History (check all that apply)

Living arrangements	□ live alone □ does not live alone
Occupation/Exposure	□ agricultural □ office work □ other exposure
Activities of daily living	□ use a cane □ use a walker □ use a wheelchair □ problems using toilet □ no problems using toilet □ rely on others for transportation
Foreign travel/living	□ has recently traveled outside U.S.
Exercise	□ regularly □ occasionally □ rarely □ never
Education	□ currently attending school
Employment status	□ working full time □ working part time □ disabled □ retired □ not working

Smoking Hx:

□ active smoker: # of cigarettes/day: ___ for: ___ years.
□ former smoker: # of cigarettes/day: ___ for: ___ years; stopped: ___ years ago.
□ never smoked.

Alcohol consumption:

□ never
□ socially (2-3 times a year)
□ occasionally (2-3 times a month)
□ frequently (2-3 times a week)
□ 1 drink daily*
□ 2-3 drinks daily*
□ more than 3 drinks daily*
* one glass of wine/one beer/one shot glass of liquor are considered one drink.

Recreational drugs use:

□ current user: type of drug:_____ frequency: _____last time used:_____
□ former user: type of drug:___ _____ frequency: _____ last time used:_____
□ never used

KARNOSKY SCALE (Please circle one)

100% - Normal; no complaints and no evidence of disease
90%- Able to carry on normal activities; minor signs or symptoms of disease
80%- Normal activities but with effort; some signs of symptoms or disease
70%- Cares for self, but is unable to carry on normal activities or to do active work
60%- Requires occasional assistance, but is able to care for most needs
50%- Requires considerable assistance and frequent medical care
40%- Disabled; requires special care and assistance
30%- Severely disable; hospitalization is indicated but death is not imminent
20%- Hospitalization necessary, very sick, active supportive treatment necessary
10%- Moribund; fatal processes progressing rapidly

Patient Name:_____ **Date:_____**

HAVE YOU EVER BEEN DIAGNOSED WITH:

Ehlers Danlos Syndrome (EDS) or other connective tissue disorder?

□ NO

□ YES: when did you experience the first symptoms? _____
any precipitating event? _____
year the diagnosis was made: _____ by: _____

Chiari Malformation?

□ NO

□ YES: when did you experience the first symptoms? _____
any precipitating event? _____
year the diagnosis was made: _____ by: _____

Tarlov Cyst?

□ NO

□ YES: when did you experience the first symptoms? _____
any precipitating event? _____
year the diagnosis was made: _____ by: _____

Other Medical History

ILLNESS	Onset (year)	Related to today's visit?

Patient Name:_____ **Date:**_____

Family Medical History

Relative (e.g. mother, father, etc.)	**L**: living **D**: deceased	Age	Illness(s)

Surgical History

Surgery	Year

Patient Name:_____ **Date:_____**

STANDING TIME (Please circle one)

0 - On most occasions, I can stand as long as necessary without experiencing orthostatic symptoms
1- On most occasions, I can stand *more than 15 minutes* before experiencing orthostatic symptoms
2- On most occasions, I can stand *5-14 minutes before* experiencing orthostatic symptoms
3- On most occasions, I can stand *1-4 minutes before* experiencing orthostatic symptoms
4- On most occasions, I can stand *less than 1 minute before* experiencing orthostatic symptoms

ORTHOSTATIC (Please circle one)

1. **Frequency of orthostatic symptoms**
   - 0- I *never or rarely* experience orthostatic symptoms when I stand up
   - 1- I *sometimes* experience orthostatic symptoms when I stand up
   - 2- I *often* experience orthostatic symptoms when I stand up
   - 3- I *usually* experience orthostatic symptoms when I stand up
   - 4- I *always* experience orthostatic symptoms when I stand up
2. **Severity of orthostatic symptoms**
   - 0- I *do not* experience orthostatic symptoms when I stand up
   - 1- I experience *mild* orthostatic symptoms when I stand up
   - 2- I experience *moderate* orthostatic symptoms when I stand up and *sometimes* have to sit back down for relief
   - 3- I experience *severe* orthostatic symptoms when I stand up and *frequently* have to sit back down for relief
   - 4- I experience *severe* orthostatic symptoms when I stand up and *regularly faint* if I do not sit back down
3. **Conditions under which orthostatic symptoms occur**
   - 0- I *never or rarely* experience orthostatic symptoms under any circumstances
   - 1- I *sometimes* experience orthostatic symptoms under certain conditions, such as prolonged standing, a meal, exertion (e.g. walking), or when exposed to heat (e.g. hot day, hot bath, hot shower)
   - 2- I *often* experience orthostatic symptoms under certain conditions, such as prolonged standing, a meal, exertion (e.g. walking), or when exposed to heat (e.g. hot day, hot bath, hot shower)
   - 3- I *usually* experience orthostatic symptoms under certain conditions, such as prolonged standing, a meal, exertion (e.g. walking), or when exposed to heat (e.g. hot day, hot bath, hot shower)
   - 4- I *always* experience orthostatic symptoms when I stand up; the specific conditions do not matter
4. **Activities of daily living**
   - 0- My orthostatic symptoms *do not interfere* with activities of daily living (e.g. work, chores, dressing bathing)
   - 1- My orthostatic symptoms *mildly interfere* with activities of daily living (e.g. work, chores, dressing bathing)
   - 2- My orthostatic symptoms *moderately interfere* with activities of daily living (e.g. work, chores, dressing bathing)
   - 3- My orthostatic symptoms *severely interfere* with activities of daily living (e.g. work, chores, dressing bathing)
   - 4- My orthostatic symptoms *severely interfere* with activities of daily living (e.g. work, chores, dressing bathing)/ *I am bed or wheelchair bound because of my symptoms*

Patient Name:_____ **Date:_____**

WOOD MENTAL FATIGUE INVENTORY

In the last month, have you been bothered by each of the following? (Please check the most appropriate box)

	Not at All	**A Little**		**Some-what**	**Quite A Lot**	**Very Much**
Spells of confusion	( )	( )	( )	( )	( )	
Thoughts getting mixed up	( )	( )	( )	( )	( )	
Poor Concentration	( )	( )	( )	( )	( )	
Difficulty making decisions	( )	( )	( )	( )	( )	
Poor memory for recent events	( )	( )	( )	( )	( )	
Can't take things in when speaking to people	( )	( )	( )	( )	( )	
Thoughts are slow **(CONTINUED)**	( )	( )	( )	( )	( )	
Muzzy or foggy head	( )	( )	( )	( )	( )	
Can't find the right words	( )	( )	( )	( )	( )	
Scoring for each item:	**0**	**1**		**2**	**3**	**4**

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40%- Disabled; requires special care and assistance
30%- Severely disable; hospitalization is indicated but death is not imminent
20%- Hospitalization necessary, very sick, active supportive treatment necessary
10%- Moribund; fatal processes progressing rapidly

Patient Name:_____ **Date:_____**

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Circle One Number on Each Line)

	Yes, Limited a Lot (1)	Yes, Limited a Little (2)	No, Not limited at All (3)
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
Lifting or carrying groceries	1	2	3
Climbing several flights of stairs	1	2	3
Climbing one flight of stairs	1	2	3
Walking more than a mile	1	2	3
Walking several blocks	1	2	3
Walking one block	1	2	3
Bathing or dressing yourself	1	2	3

Patient Name:_____ **Date:**_____

Indicate severity using number scale | 1 = None | 2 = Mild | 3 = Moderate | 4 = Severe | 5 = Incapacitating

NEUROLOGICAL						**MUSCULOSKELETAL**					
Hyperaccusis/sensitivity to noise	1	2	3	4	5	Neck pain on bumpy roads	1	2	3	4	5
Ringing in the ears	1	2	3	4	5	Muscle pain at rest	1	2	3	4	5
Loss of hearing	1	2	3	4	5	Cramps/stiff muscles	1	2	3	4	5
Balance disorder	1	2	3	4	5	Pain in legs while walking	1	2	3	4	5
Vertigo (room spinning around)	1	2	3	4	5	Back pain when lying down	1	2	3	4	5
Dizziness/lightheadedness	1	2	3	4	5	Scoliosis	1	2	3	4	5
Shaking episodes (dystonias)	1	2	3	4	5	Back pain walking up incline	1	2	3	4	5
Seizures	1	2	3	4	5	Lower back pain	1	2	3	4	5
Tremors	1	2	3	4	5	Sacral pain	1	2	3	4	5
Headache	1	2	3	4	5	Sleep with knees bent	1	2	3	4	5
Neck pain	1	2	3	4	5	**CARDIOVASCULAR/AUTONOMIC NERVOUS SYSTEM**					
Loss of consciousness/syncope	1	2	3	4	5	Feeling heart beats/palpitations	1	2	3	4	5
Pre-syncope	1	2	3	4	5	Chest tightness/pain at rest	1	2	3	4	5
Concentration difficulties	1	2	3	4	5	Chest pain on exertion	1	2	3	4	5
Memory loss	1	2	3	4	5	Shortness of breath at night	1	2	3	4	5
Blurred vision	1	2	3	4	5	Shortness of breath at rest	1	2	3	4	5
Double vision	1	2	3	4	5	Shortness of breath on exertion	1	2	3	4	5
Teichopsia (vision flashes)	1	2	3	4	5	Fingers change color with temperature	1	2	3	4	5
Photosensitivity (light sensitivity)	1	2	3	4	5	Excessive sweating	1	2	3	4	5
Hyperolfaction (sensitivity to smell)	1	2	3	4	5	Heat intolerance	1	2	3	4	5
Facial numbness	1	2	3	4	5	Elevated temperature of >101.5 °	1	2	3	4	5
Paresthesia/tingling/sensory loss	1	2	3	4	5	Sleep disturbances	1	2	3	4	5
Leg weakness	1	2	3	4	5	Abnormally dilated pupils	1	2	3	4	5
Arm weakness	1	2	3	4	5	**GASTROINTESTINAL**					
Nausea/vomiting	1	2	3	4	5	Abdominal pain	1	2	3	4	5
Poor coordination	1	2	3	4	5	Bloating	1	2	3	4	5
Speech difficulty	1	2	3	4	5	Constipation	1	2	3	4	5
Hoarseness	1	2	3	4	5	Heart burn/ GERD	1	2	3	4	5
Choking	1	2	3	4	5	Diarrhea	1	2	3	4	5
Difficulty swallowing	1	2	3	4	5	Black stool/blood in stool	1	2	3	4	5
CONSTITUTIONAL						Loss of bowel control	1	2	3	4	5
Fatigue	1	2	3	4	5	**GENITOURINARY**					
Rashes	1	2	3	4	5	Burning with urination (dysuria)	1	2	3	4	5
Easily bruised	1	2	3	4	5	Increased frequency / urination	1	2	3	4	5
Joint pain	1	2	3	4	5	Loss of bladder control	1	2	3	4	5
Poor wound healing	1	2	3	4	5	Nocturia (urination at night)	1	2	3	4	5
Frequent infections	1	2	3	4	5	Difficulty initiating stream	1	2	3	4	5
Anemia	1	2	3	4	5	Unable to empty bladder	1	2	3	4	5
Excessive bleeding	1	2	3	4	5	Enuresis (bedwetting)	1	2	3	4	5
Swollen lymph nodes	1	2	3	4	5	**PSYCHIATRIC**					
Thyroid disorder	1	2	3	4	5	Depression	1	2	3	4	5
						Anxiety/panic	1	2	3	4	5

Patient Name:_____ **Date:**_____

OTHER PERTINENT INFORMATION YOU WOULD LIKE TO ADD: