ANTHONY G. ALESSI, M.D.
NEURO DIAGNOSTICS, LLC
MEDICAL INFORMATION FORM

Today's Date: _______________

Patient's Name: ____ **Age:** _____
(First) *(Middle)* *(Last)*

Chief Complaint: ____

Circle One: Right Handed Left Handed **HT:** _________ **WT:** ______ **Are You Pregnant? Yes** ___ **No** ___

Smoker: _______ Pack/Day **Non-Smoker:** _____ # of Years **Alcohol:** _____ # Drinks/Day

Please list current medications (include Vitamins and Supplements): ____

____

List Surgery(s) and Date(s): ____

____

Allergies: ____

Please CHECK Yes or No – Do you have or ever had:

Yes	No		Yes	No	
___	___	Cancer – If Yes, When ____________	___	___	Pain/Numbness – If Yes, Where ____________
		Treatment Performed ____________	___	___	Asthma – If Yes, What Inhalers ____________
___	___	Diabetes – If Yes, # of Years ____________	___	___	Pacemaker – If Yes, Date Inserted ____________
___	___	Seizures – If Yes, When Diagnosed ____________	___	___	Heart Attack – If Yes, When ____________
___	___	Head Trauma(Concussion)–If Yes, When _____	___	___	Hypertension (High Blood Pressure) ____________
___	___	Stroke/TIA – If Yes, When Diagnosed ________	___	___	Hepatitis ____________
___	___	Migraines(Headaches) – If Yes, # of Years ___	___	___	Arthritis ____________
___	___	Thyroid Disease ____________	___	___	Depression ____________
___	___	Vertigo (Dizziness) ____________	___	___	Other ____________

Family History:

Yes	No		Yes	No	
___	___	Heart Disease ____________	___	___	Stroke ____________
___	___	Diabetes ____________	___	___	Brain Aneurysm ____________
___	___	Neurological Disease ____________	___	___	Other ____________

Please CIRCLE any of the following symptoms you are experiencing:

General: Weight Loss Weight Gain
GI: Nausea Vomiting Difficulty Chewing Difficulty Swallowing Heartburn Diarrhea Constipation
GU: Urinary Retention Urinary Frequency Incontinence
Psychiatric: Depression Mood Swings Confusion
Cardiac: Shortness of Breath on Exertion Chest Pain Palpitations
Nasal: Nosebleeds Sinus Infections Congestion
Respiratory: Persistent Cough Wheezing
Auditory: Ringing in Ears Ear Pain Hearing Loss
Visual: Glasses or Contacts Double Vision Visual Changes Eye Pain
Vascular: Leg Pain when Walking Swelling of Ankles Cold Limbs
Sleep: Insomnia Excessive Sleepiness Daytime Sleepiness
Spine: Neck Pain Low Back Pain
Neurological: Headaches Weakness Numbness Loss of Conscious

ANTHONY G. ALESSI, M.D.
NEURO DIAGNOSTICS, LLC

MEDICAL INFORMATION FORM

Please print clearly!

GENERAL

Patient's Name: ______________________________
(First) *(Middle)* *(Last)*

Address: ______________________________
(Street) *(City, State)* *(Zip Code)*

Best Contact Phone ____________ **Other** ____________ **Work** ____________

Birthdate: ________ **SS#:** ____________ *(optional)* **Marital Status:** ________

Primary Care Physician: ______________________________

Referring Physician: ______________________________

Employer: ____________________ **Address:** ____________________

In Case of Emergency, Contact: ____________________ **Telephone:** ( ) ____________

Relationship: ____________ **Address** ______________________________

If we have NOT made a copy of your Insurance Card:

INSURANCE

Primary Insurance Company: ____________________ **Policy #:** ________

Insured Name ______________________________

Insured SS #: ____________ **DOB** *(If Different from Patient)*: ________

Employer: ______________________________

ID #: ____________________ **Group #:** ____________________

Is there a Secondary Insurance? Yes ____ **No** ____

Secondary Insurance Company: ____________________ **Policy #:** ________

Insured Name ______________________________

Insured SS #: ____________ **DOB** *(If Different from Patient)*: ________

Employer: ______________________________

ID #: ____________________ **Group #:** ____________________

Worker's Comp: Yes ____ **No** ____ **Motor Vehicle: Yes** ____ **No** ____

Who may we thank for referring you? ______________________________

FINANCIAL INFORMATION

I hereby authorize my insurance benefits to be paid directly to my provider or myself and acknowledge that I am financially responsible for any unpaid balance. I also authorize this office to release any information required by my Insurance Company.

Signature: ______________________________ **Date:** ____________
(Patient, Parent if Minor)