LOYOLA MEDICINE | Loyola University Medical Center

Department of Neurology

Thank you for choosing Loyola University Health System. Our goal is to see our patients at their scheduled appointment time. Please arrive 20 minutes prior to your scheduled appointment for check-in and insurance confirmation. If you arrive late, you may be asked to reschedule or be seen at the end of clinic. Please also bring the following items to your appointment.

1. Your insurance card or other information.
2. A physician referral, if needed.
3. The name and address of the physician who referred you to this appointment.
4. If attached, please complete and bring medical history form.
5. Copies of ALL medical records and pertinent films (X-Rays, CT, MRI, Angiogram).
6. Bottles of the current medications you are taking.
7. The co-payment portion of your clinic bill.
8. Please read and complete the **PATIENT CANCELATION AND REFILL** form.

You will also receive a Loyola phone call reminder the day and two prior to the appointment.

In addition to prompt arrival for a scheduled appointment, we request at least a 24 hour notification of an appointment you are unable to keep. We will then be able to offer your appointment time to another patient waiting to see a Loyola neurologist. If 2 consecutive new patient appointments are missed without prior notification, you will be unable to reschedule a new visit with a neurologist at Loyola. Please cancel by calling **708-216-6006**, 24 hours prior to an appointment.

If needed, Loyola Medicine is also offering two types of virtual visits, at this time: video visits or telephone visits. (please see telehealth for patient care). Please complete this form 5-7 days prior to your telehealth appointment.

We look forward to serving your healthcare needs.

Sincerely,

The Neurology Staff

Loyola University Medical Center

Department of Neurology

PATIENT CANCELATION AND REFILL POLICIES

Cancelation Policy

- Missed appointments can create considerable disruption for other patients, our office staff, our nurse, advanced practice nurse, and the physician. A phone call from you can prevent these disruptions to allow other patients the opportunity to access medical care (**708-216-6006**).
- If you fail to present (no show) for six consecutive follow up appointments in an 18-month period, you will be asked to seek medical care outside Loyola.
- We are certainly sympathetic to problems that arise on occasion and prevent you from keeping your scheduled appointment. We appreciate your help in notifying us as soon as possible if you unable to keep a scheduled appointment (**708-216-6006**).

Medication Refill

- For prescription refills, please contact your pharmacy. The pharmacy will fax a refill request to your doctor.
- No short-term prescriptions such as pain medications will be given without an appointment.
- Patient on long-term medication need to be evaluated every 6-12 months before a refill can be given.
- If a refill is needed before your next appointment, have your pharmacy fax the request to **708-216-2683**. Please allow 24-48 hours for the refill request(s) to be processed.

Please arrive 20 minutes prior to your scheduled appointment for check in and insurance confirmation.

I acknowledge understanding of the importance of informing the clinic if unable to make an appointment and how to refill prescriptions.

Name: _____

Date: _____

Loyola University Medical Center

BACKGROUND INFORMATION FORM

Department of Neurology

Please take your time when filling out this form. This information will help us with your medical evaluation.

PLEASE PRINT

Name:_____

Birthdate: _____ **Age**: _____

Circle one: MALE FEMALE **Circle one**: Right handed Left Handed

Native language: _____

What is the name, address and phone of the doctor referring you to Neurology?

Name: _____ Phone: _____

Address: _____

What is the name and address of your primary care physician?

Name: _____ Phone: _____

Address: _____

Please list the names/addresses/phone numbers of other physicians you have seen in the past 3 years.

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

For what medical problem(s) are you being seen today? Describe symptoms.

_____

_____

_____

_____

_____

_____

_____

_____

Please list the medications you are taking (including over-the-counter, herbals, and supplements).

Name of Medication	Dose	Times a day	Reason	Start Date

Are you allergic to any medication(s)? Circle one: YES NO

Drug	Reaction	Date

Have you had any surgeries? Circle one: YES NO

Type of Surgery	Hospital and/or Physician	Date

If you have headaches, have you experienced (Circle one):

Facial Pain? YES NO

Lacrimation? YES NO

Sinus pressure? YES NO

Nasal discharge? YES NO

Nasal congestion? YES NO

Fever? YES NO

Changes in sense of smell? YES NO

Increased sensitivity to bright light? YES NO

Increased sensitivity to sounds? YES NO

Increased sensitivity to certain smells/odors? YES NO

Nausea? YES NO

Vomiting? YES NO

Weather trigger? YES NO

Duration in minutes/hours/days? _____

Frequency (number of headaches per month)? _____

If you have memory difficulties, have you noticed (Circle one):

Being more forgetful? YES NO

Losing your train of thought? YES NO

Problems trying to find the right word or remembering words to use? YES NO

Problems remembering when and how to take medications? YES NO

Problems remembering appointments? YES NO

Losing things around the house only to have them turn up later? YES NO

Difficulty remembering the names of family members or close friends? YES NO

Difficulty following conversations? YES NO

Problems forgetting conversations? YES NO

Difficulties using things around the house such as the coffee maker, vacuum, or telephone? YES NO

Forgetting to turn things off such as the lights or stove? YES NO

Getting lost around the house, in the neighborhood, or while driving? YES NO

Keeping track of time? YES NO

Others expressing a concern about your memory? YES NO

Others expressing concern about you repeatedly asking the same question, only to forget the answer? YES NO

Are there any safety concerns? YES NO

- **Driving** YES NO
- **Disorientation when driving** YES NO
- **Recent traffic violation or accidents** YES NO
- **Passenger concerns** YES NO
- **Safety concerns at home** YES NO

THIS SECTION FOR PATIENTS WITH PRIOR HISTORY OF COVID-19 ONLY

Were you hospitalized for COVID-19 related illness? YES NO

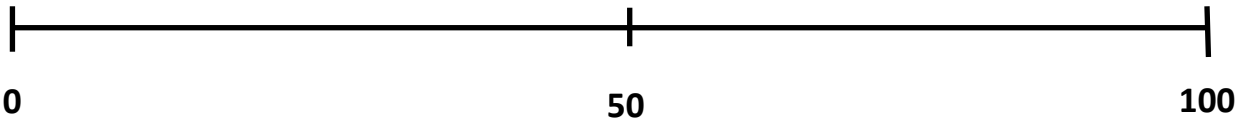
If yes, how long was your stay in the hospital? _____

Where you on a ventilator during your hospitalization? YES NO

If yes, for how long were you on the ventilator? _____

Since your COVID-19 diagnosis, have you had any of these symptoms/concerns lasting longer than 3 months from your COVID diagnosis?

Chronic fatigue YES NO If yes, please mark on the scale below your daily average fatigue severity. 0 = Not fatigued at all to 100 = Fatigue as bad as can be



Post-exertional lack of energy YES NO

Confusion YES NO

Anxiety YES NO

Irritability YES NO

Depression YES NO

Mood changes YES NO

Tearfulness YES NO

Anger YES NO

Impulsivity YES NO

Disinhibition (actions which seem tactless, rude, or offensive) YES NO

Aggression YES NO

Euphoria YES NO

Delusions YES NO

Mania YES NO

Suicidal thoughts YES NO

Brain fog YES NO

Memory issues YES NO

Slurring words YES NO

Change of smell and/or taste YES NO

Headaches, either new or worsening YES NO

Dizziness and balance issues YES NO

Worsening of symptoms while standing or sitting upright YES NO

Vertigo YES NO

Nerve pain/muscle pain & aches/cramps YES NO

Limb numbness YES NO

Limb weakness YES NO

Tremors YES NO

Hallucinations YES NO

Insomnia YES NO

Other sleeping issues YES NO

[End of COVID-related questions – please complete the next sections of the form]

THIS SECTION FOR PATIENTS WITH HISTORY OF VERTIGO/DIZZINESS

Have you had at least 5 episodes with any of the symptoms below, lasting 5 minutes to 72 hours?

Sense of floating YES NO

Sense of unsteadiness YES NO

Sense of rocking YES NO

Walking on air or pillows YES NO

Feel "drunk" YES NO

Feel "sea sick" YES NO

Feel foggy YES NO

Feel like your eyes do not catch up with your head movements YES NO

Fees like you are wearing the wrong prescription lenses YES NO

Are any of the above symptoms triggered by:

Big box stores or shopping malls YES NO

Crowds YES NO

Fluorescent lights YES NO

Watching traffic/Windshield wipers YES NO

Patterns such as: checks, stripes, zig-zags, tiled floors YES NO

Bridges, escalators, tunnels YES NO

Watching large screens or 3D movies YES NO

Other symptoms such as:

Muffled hearing YES NO

Ear pressure YES NO

Ear pain YES NO

Ringing in the ears YES NO

Chronic motion sickness YES NO

Nausea and/or vomiting YES NO

Fatigue YES NO

Anxiety YES NO

[End of Vertigo/Dizziness questions – please complete the next sections of the form]

Do you have any other conditions or symptoms? Please circle all that apply.

General	**Height change, energy loss, fevers, cold or heat intolerance, night sweats, changes in hair/nails, failure to gain weight, short stature, cancer, COVID-19 exposure/test**	**NONE**
Sleep	**Snoring, sleep apnea, stop breathing during the night, daytime sleepiness, trouble falling asleep, frequent awakenings, trouble staying asleep, nightmares, limbs moving during sleep**	**NONE**
Allergies	**Latex, lidocaine, aspirin, sulfa, penicillin, vaccines, bee stings, eggs, hay fever, seafood, peanuts, milk, anti-seizure medications, other _____**	**NONE**
Immune	**Frequent infections, swollen glands, runny nose, allergic reactions, lupus**	**NONE**
Eyes	**Cataracts, glaucoma, blurred vision, blindness, light sensitivity, night blindness, double vision, lazy eye, drooping eyelids**	**NONE**
Skin	**Rash, itching, color changing, flushing**	**NONE**
ENT	**Cochlear implant, hearing loss, ringing in ears, sinus problems, sore throat, changes in voice, trouble swallowing, tonsillitis, difficulty chewing, abnormal teeth**	**NONE**
Heart	**Murmur, chest pain, high blood pressure, circulation problems, blocked arteries, irregular heartbeat, rheumatic fever, swelling in feet, coil(s), stent(s), artificial heart valve, pacemaker**	**NONE**
Respiratory	**Shortness of breath, wheezing, cough, asthma, emphysema, pneumonia, tuberculosis**	**NONE**
Digestive	**Abnormal pain, heartburn, ulcers, loss of appetite, nausea, vomiting, constipation, diarrhea, bloating, blood in stool, diverticulitis, gall bladder problems, appendicitis, liver problems, pancreatitis, hernia, choking**	**NONE**
Bladder	**Loss of bladder control, frequent urination, painful urination, difficulty passing urine, blood in urine, kidney stones, kidney failure**	**NONE**
Endocrine	**Diabetes, thyroid problems, pituitary problems, adrenal problems, high cholesterol, hormone problems**	**NONE**
Reproductive	**Are you pregnant?** **Problem with sexual function, menstrual problems, pregnancy/miscarriages, breast lump, nipple discharge**	**Y / N** **NONE**
Hematologic	**Anemia, nose/gum bleeding, bruise easily, bleed easily, blood clots, leukemia, lymphoma, myeloma**	**NONE**

Musculo-skeletal	**Muscle weakness, muscle pain, leg cramps, muscle twitching, stiffness, arthritis, joint pain, gout, neck pain, back pain, slipped disc, osteoporosis, fractures, bone disease**	**NONE**
Neurologic	**Loss of smell, visual loss in one eye, double vision, headaches, migraines, dizziness, vertigo, fainting, convulsion, seizures, epilepsy, stroke, brief episodes of arm or leg weakness/numbness, head injury, meningitis, memory loss, trouble concentrating, trouble speaking, trouble understanding, handwriting changes, paralysis, tremor, problem with balance, trouble walking, pinched nerve, neuropathy, numbness, tingling, seeing or hearing things that aren't there, multiple sclerosis, Guillain-Barré syndrome, tics, bladder incontinence, bladder retention, vagal nerve stimulator, spinal cord stimulator, aneurysm clips, carotid stent, other implantable device**	**NONE**
Psychiatric	**Behavior changes, mood changes, depression, anxiety, feeling down in the dumps, bipolar, nervous breakdown, alcohol dependence, drug addiction, hyperactivity, impulsivity, oppositional behavior, obsessive, poor attention span, aggressive behavior**	**NONE**
Miscellaneous	**Are you claustrophobic?**	**Y / N**

Basic Self-Care Tasks

Do you have problems with any of the following?

Feeding? YES NO **Grooming?** YES NO

Dressing? YES NO **Bathing?** YES NO

Usual household chores? YES NO **Managing finances?** YES NO

Toileting including bladder/bowel control? YES NO

Mobility including transfers from one place to another? YES NO

Other Information:

Marital Status? Circle one: Married Divorced Separated Widowed

Who else live with you? _____

Work status? Circle one: Working Unemployed On leave On disability Retired

What is your occupation (or former occupation if not currently working)?

How many years did you go to school? _____

What is the last school you attended? _____

Have you ever smoked? Circle one: YES NO QUIT **When**:_____

For how long did you smoke? _____ Packs per day? _____

Do you drink alcohol? Circle one: YES NO

How many drinks per week? ____ Have you ever been a heavy drinker? _____

Do you use caffeine? Circle one: YES NO **How much per day? _____**

Have you been exposed to any environmental hazards? Circle one: YES NO

If yes, what? _____

Is there any pending legal action related to your current condition? _____

Please explain:

_____

_____

_____

Family History:

Do any of your blood relatives have a similar condition(s) as you have?

If so, who?_____

Please list medical conditions in your family (use extra paper if necessary):

Relationship	Age	Still Living?	Conditions	Cause of Death
Father				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandmother				

Maternal Grandfather				
Sister				
Brother				

Will you allow a Loyola University Medical Center researcher to contact you about participating in clinic research? Your response in no way affects the kind of clinical care you receive.

Circle one: YES NO

Signature of patient _____

Date _____

Name of person completing this form if not patient (please print):

_____

Relationship to patient:_____

Signature _____

Date _____

(Office use only)

Reviewed by: _____

Date: _____