

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:

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
___	___	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:			___	___	Stroke _____
___	___	Heart Disease _____	___	___	Brain Aneurysm _____
___	___	Diabetes _____	___	___	Other _____
___	___	Neurological Disease _____			

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!

**G
E
N
E
R
A
L**

Patient's Name: _____
(First) (Middle) (Last)

Address: _____
(Street) (City, State) (Zip Code)

Home Phone: () _____ **Work Phone:** () _____

Birthdate: _____ **SS#:** _____ **Marital Status:** _____
(optional)

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:

**I
N
S
U
R
A
N
C
E**

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)