

PERIPHERAL NERVE HISTORY FORM

IF THIS IS YOUR FIRST VISIT, PLEASE TAKE THE TIME TO FILL THIS FORM OUT COMPLETELY.

Patient Name: _____ Age: _____ Date of Birth: _____ Weight: _____ Height: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
E-mail address _____ Emergency Contact _____
Emergency Contact Info _____
Emergency Contact relationship to you _____
Social Security#: _____ Occupation: _____
Reason for today's visit: _____

Primary Care Physician: _____ Phone: _____ Fax _____
Address _____ City/State _____ Zip _____

Referring Physician: _____ Phone: _____ Fax _____
Address _____ City/State _____ Zip _____

How Did You Hear About Us? _____

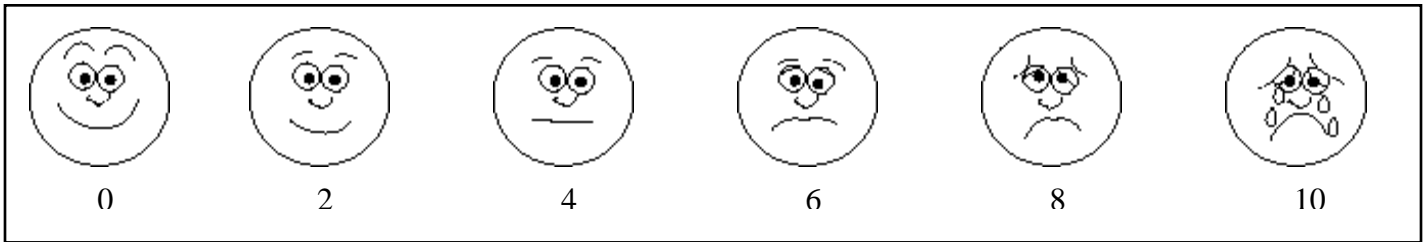
Primary Insurance: _____ Phone #: _____
Address: _____ Policy #: _____ Group #: _____
Policy Holder: _____ Social Security #: _____ DOB: _____

Secondary Insurance: _____ Phone #: _____
Address: _____ Policy #: _____ Group #: _____
Policy Holder: _____ Social Security #: _____ DOB: _____

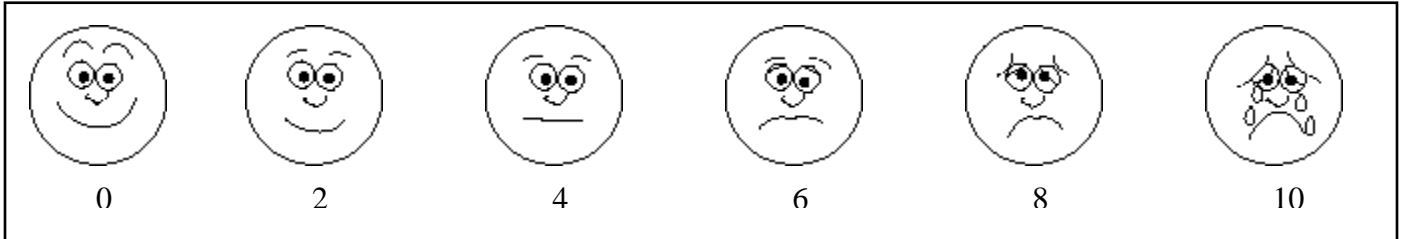
PAYMENT OPTIONS:

1. MasterCard & Visa are accepted
2. Personal checks are accepted at least 14 days prior to surgery
3. Payment financing is available via Care Credit

4. Please circle the face that shows your pain at its **best**:



5. Please circle the face that shows your pain at its **worst**:



6. Where is your pain? Mark the areas on your body where you are feeling pain.



7. Circle the word(s) that best describe your pain

Aching Throbbing Shooting Stabbing Gnawing Sharp Tender
Burning Exhausting Tiring Nagging Penetrating Numb Miserable

8. Is your pain: Continuous Occasional

9. Circle the time of day you pain is worse Morning Afternoon Evening Night

10. What makes your pain better? _____

11. What makes your pain worse? _____

If The Reason For Your Visit Today Is Nerve Related, Please Take The Time To Fill Out The Following:

12. How long have you had nerve problems? _____
13. Are you taking any medication(s) for your pain? _____ If so, which medication(s)

14. Have you ever had an EMG? _____ If so, When? _____
15. Do you have Diabetes? _____ If so, when were you diagnosed? _____
16. Have you had Chemotherapy? _____ If so, when? _____ for how long? _____
How many cycles? _____ Which chemotherapy medication(s) _____
17. Have you been exposed to heavy metals (Arsenic, Lead, Mercury) _____ If so, how? _____
18. Do you have any back or spine problems? _____ Have you had back or spine problems? _____
Have you had back or spine surgery? _____ If you answered yes to any of the above, please
describe _____

Do you currently have any of the following conditions?

	YES	NO		YES	NO		YES	NO
EYES			ENDOCRINE			GENITOURINARY		
Cataract(s)	<input type="checkbox"/>	<input type="checkbox"/>	Insulin dependent diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pain w/ urination	<input type="checkbox"/>	<input type="checkbox"/>
Visual disturbance(s)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes controlled with pills	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder infection	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes controlled with diet	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stone(s)	<input type="checkbox"/>	<input type="checkbox"/>
Retinal problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
EAR, NOSE, THROAT			Parathyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinus drainage	<input type="checkbox"/>	<input type="checkbox"/>	CARDIAC			MUSCULOSKELETAL		
Nasal breathing issues	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Swelling	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY			Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Herniated disk	<input type="checkbox"/>	<input type="checkbox"/>
Use oxygen at home	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Back pain/injury	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGIC		
GASTROINTESTINAL			Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chronic nausea	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac bypass	<input type="checkbox"/>	<input type="checkbox"/>	TIA (AKA "minor stroke")	<input type="checkbox"/>	<input type="checkbox"/>
Chronic vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac catheterization	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	SKIN		
Black/bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	HEME/LYMPH			Moles	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Recent lymph node swelling	<input type="checkbox"/>	<input type="checkbox"/>	Poor scarring	<input type="checkbox"/>	<input type="checkbox"/>
Gall stones	<input type="checkbox"/>	<input type="checkbox"/>	Chronic lymph node swelling	<input type="checkbox"/>	<input type="checkbox"/>			
Hernia(s)	<input type="checkbox"/>	<input type="checkbox"/>						
Spleen problems	<input type="checkbox"/>	<input type="checkbox"/>						

PAST MEDICAL HISTORY:

Have **you ever** had any of the following?

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral valve prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	MIGRAINES	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer (other)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

If yes to any of the above, please describe the condition: _____

PAST SURGICAL HISTORY (including cosmetic surgery):

Please list any previous surgery with approximate dates:

Procedure	Date	Procedure	Date

FAMILY HISTORY:

Do you have **family members** with any of the following conditions:

Breast Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
MIGRAINES	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes to any of the above, please describe the condition and identify your relation to the family member: _____

MEDICATIONS:

Please list any prescription, non-prescription, and herbal medications you are taking along with doses. If you have a long list, please bring it to us.

DRUG ALLERGIES: _____

SOCIAL HISTORY:

Marital Status: _____ Spouse's name _____

Are you currently employed? yes ___ no ___ If so, what do you do? _____

Do you smoke? yes ___ no ___ If so, how many packs per day? _____

If you smoked in the past, when did you quit? _____

On average, how many alcoholic drinks do you have per week? _____

OFFICE & INSURANCE BILLING AUTHORIZATION AND NOTIFICATION

By my signature below, I am authorizing PELED PLASTIC SURGERY to bill my insurance company for services provided. Occasionally, insurance companies send the insured party (yourself) reimbursement directly for medical services provided by their doctors. In such an event, any monies received directly by me for services rendered by Dr. Peled will be forwarded to this office within 2 weeks of receipt. In addition, any co-pays or deductibles will be paid in full within 2 weeks of any procedure or office visit as applicable. I further understand that Dr. Peled may or may not be a participating provider with my insurance plan. As such, the allowed amount according to my insurance company for any services/procedures rendered may be less than the amount charged by PELED PLASTIC SURGERY and I acknowledge that the difference will be my responsibility. I also acknowledge and understand that there will be a fee of \$25.00 (per form up to 4 pages and an additional \$25.00 fee for each additional 4 pages of paperwork over the initial 4 pages) to complete any paperwork associated with my care. Finally, any appointments not cancelled **AT LEAST 24 HOURS** prior to the scheduled time will be subject to a \$50 cancellation fee. I further acknowledge that any questions regarding these matters have been answered by Dr. Peled and/or his staff.

Printed Name

Signature

Date

If not signed by patient, please indicate relationship to patient (e.g. spouse)

Relationship

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have been presented with a copy of Peled Plastic Surgery’s ‘Notice of Privacy Practices’ (ask Cary-Anne for a paper copy; they are also available online at all times at this address - <http://www.peledmigrainesurgery.com/forms.html>), detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of these ‘Practices’, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical
Board of California
(800) 633-2322
www.mbc.ca.gov

Printed Name

Signature

Date

If not signed by patient, please indicate relationship to patient (e.g. spouse)

Relationship