OREGON NEUROSURGERY

3355 RiverBend Drive, Suite 400, Springfield, OR 97477

(541) 686-8353

Your appointment details: Your appointment is at:

- 3355 RiverBend Drive, Suite 400, Springfield

Please help us ensure your appointment time and reduce your waiting time by doing the following:

- If this visit is related to an MVA (motor vehicle accident) or Workers Compensation claim, please contact our office immediately to verify we have the correct billing information or your visit may be rescheduled.
- Complete the enclosed forms
- Mail them in the enclosed envelope
- Important notice to nicotine users: For certain surgeries, insurances are requiring documentation of nicotine-free status verified by lab results, prior to authorizing surgery. Labs are to be ordered and monitored by your primary care physician.

For all new patients, we request that you be in our office 20 minutes prior to your scheduled appointment time. If you do not have the following paperwork filled out when you arrive, you may be rescheduled.

****Important information regarding our practice policies ****

- **LATE SHOW POLICY –** If you are late 5 minutes or more to your appointment you will be asked to reschedule to the net available appointment date and time.
- **PAIN MEDICATIONS –** No pain medications and or muscle relaxers are prescribed by our physicians prior to surgery. Should surgery be indicated, pain management would start the day of the surgery and continue only for 6 weeks post operatively.
- **DISABILITY, OFF WORK, WORK RESTRICTIONS AND MEDICAL LEAVE** Should surgery be indicated, these issues will be addressed starting the day of surgery and during the post-operative care only.

By signing below, I agree that I understand the information above regarding the practice policies.

_____

Signature of patient or person authorized to sign for patient – Relationship Date Time

Please be aware that if your physician has an emergency, your appointment time may be delayed or rescheduled.

If there is a week before your appointment and you have not mailed back the following paperwork, please hand carry to your appointment.

Oregon Neurosurgery
3355 RiverBend Drive, Suite 400
Springfield, OR 97477
PHONE: 541-888-8353
TOLL FREE: 800-924-8353

Patient History

Patient Name: _____ Height: _____ Weight: _____
DOB: _____ / _____ / _____ Physician: _____
Reason for today's visit? _____
Allergies: _____

MEDICATIONS (Please list medications and directions):

Medication:	**Dose and frequency:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HISTORY (Please check if you have a history of the following):

❑ Allergies	❑ Diabetes	❑ Neuromuscular disease
❑ Anemia	❑ Emphysema	❑ Osteoporosis
❑ Anxiety	❑ GERD	❑ Seizures
❑ Arthritis	❑ Glaucoma	❑ Sickle cell anemia
❑ Asthma	❑ Heart murmur	❑ Stroke
❑ Cancer	❑ HIV/AIDS	❑ Substance abuse
❑ CHF	❑ Hypertension	❑ Thyroid disease
❑ Clot disorder	❑ Kidney disease	❑ Tuberculosis
❑ COPD	❑ Meningitis	❑ Ulcers
❑ Depression	❑ Myocardial infarction	

SURGICAL HISTORY (Please check all surgeries that you have had):

❑ Appendectomy	❑ Cosmetic surgery	❑ Prostate surgery
❑ Brain surgery	❑ Eye surgery	❑ Small intestine surgery
❑ Breast surgery	❑ Fracture surgery	❑ Spine surgery
❑ C-section	❑ Hernia surgery	❑ Tubal ligation
❑ CABG	❑ Hysterectomy	❑ Valve replacement
❑ Cholecystectomy	❑ Joint replacement	❑ Vasectomy
❑ Colon surgery	❑ Other: _____	

Place patient label here

PeaceHealth Medical Group

Neurosurgery

FAMILY HISTORY (Please check which family member has the history):

Alcohol abuse	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Arthritis	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Asthma	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Birth Defects	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Cancer	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
COPD	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Depression	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Diabetes	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Drug abuse	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Early death	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Hearing loss	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Heart disease	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Hyperlipidemia	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Hypertension	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Kidney disease	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Learning disability	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Mental illness	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Miscarriages	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Stroke	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather
Vision loss	❑ Mother	❑ Father	❑ Sister	❑ Brother	❑ Grandmother	❑ Grandfather

SOCIAL HISTORY:

Alcohol use: ❑ Yes ❑ No ❑ Defer Drinks/week: _____

Drug use: ❑ Yes ❑ No ❑ Defer Type: _____ Use/week: _____

Tobacco: ❑ Former ❑ Current ❑ Never Type: ❑ Cigarettes ❑ Cigar ❑ Chewing tobacco

How many years? _____ Ready to quit? ❑ Yes ❑ No

Do you have any of the following difficulties (please check yes or no):

	Yes	No		Yes	No		Yes	No
Fall risk?			Second hand smoke exposure?			Assistive device used?		
Moving in and out of bed?			Difficulty dressing?			Difficulty bathing?		
Difficulty self-feeding?			Difficulty with toilet management?			Difficulty walking independently?		
Difficult driving?			Difficulty with phone management?			Difficulty with meal preparation?		
Difficulty with kitchen safety?			Difficulty with housekeeping?			Difficulty with money management?		
Difficulty with medication management			Wander/getting lost?			Difficulty with transportation?		

REVIEW OF SYSTEMS (Please check all symptoms you have experienced. If no symptoms, please check "none")

General ❑ Loss of appetite ❑ Night sweats ❑ Fever/chills ❑ Trouble sleeping ❑ Serious injury ❑ Unintentional weight loss ❑ Unusual fatigue ❑ None	**Pulmonology** ❑ Persistent cough ❑ Snoring ❑ Shortness of breath ❑ Wheezing ❑ None	**Neurological** ❑ Numbness/tingling ❑ Memory loss ❑ Seizures ❑ Loss of coordination ❑ Tremors/shaking ❑ Headaches ❑ Loss of balance/falls ❑ Vertigo/dizziness ❑ Change in speech/voice ❑ Muscle weakness ❑ None
Eyes ❑ Light sensitivity ❑ Loss of vision ❑ Eye pain ❑ Change in vision ❑ Double vision ❑ None	**Gastrointestinal** ❑ Constipation ❑ Nausea ❑ Blood in stool ❑ Vomiting ❑ Abdominal pain ❑ Diarrhea ❑ None	**Psychiatric** ❑ Thoughts of suicide ❑ Depression ❑ Anxiety ❑ Recent emotional upset ❑ Hallucinations ❑ None
ENT ❑ Noise sensitivity ❑ Hoarseness ❑ Jaw pain ❑ Decreased hearing ❑ Ringing in ears ❑ Decreased smell/taste ❑ Difficulty swallowing ❑ None	**Genitourinary** ❑ Frequent urination ❑ Blood in urine ❑ Pelvic pain ❑ Abnormal bed wetting ❑ Sexual difficulty ❑ Incontinence ❑ Change in menstrual cycle ❑ Painful urination ❑ None	**Endocrine** ❑ Excessive sweating ❑ Excessive thirst ❑ Feeling of excessive cold/warmth ❑ None
Cardiovascular ❑ Racing/irregular heartbeat ❑ Chest pain/discomfort ❑ Lightheadedness ❑ Swelling in hands/feet ❑ Passing out/fainting ❑ None	**Musculoskeletal** ❑ Muscle aches/cramping ❑ Back pain/neck pain ❑ Joint swelling/pain ❑ None	**Heme/Lymphatic** ❑ Enlarged lymph nodes ❑ Frequent infections ❑ Easy bleeding/bruising ❑ None
	Skin ❑ Rash/hives/skin changes ❑ Suspicious skin lesions ❑ None	**Allergy/Immunologic** ❑ Seasonal allergies ❑ HIV exposure ❑ None

PeaceHealth

Detailed Message and Patient Communication Preferences

To our patients:

You have the right to request that PeaceHealth communicate with you by alternative means or at alternate locations. Please use the attached form to tell us how you prefer to communicate with us.

You may also use this form to tell PeaceHealth who is involved in your care so that we can provide them with the information they need to assist you. If you choose to identify the individuals who are involved in your care on this form, you should be aware of the following:

- By completing and signing this form, you are indicating that your doctor and other staff (nurses, office assistants, etc.) may leave a detailed message regarding your healthcare and share limited information with the people named on the form.
- This form is completely optional. You are **NOT** required to complete it in order for us to share limited information with people involved in your care, unless you object.
- Information shared with the people named on this form will be limited to what they need to know to assist with your care at home and elsewhere. This will primarily be verbal information but may also include some written or printed information (e.g. care instructions).
- This form will not expire. We will act upon the information you provide on this form unless you inform us that it has changed.
- **This form is not a legal authorization, consent, release, or agreement.**
- This form does **NOT** grant the people named on it the right to obtain access to or copies of your health records.
- If your family member or friend wishes to obtain all or part of your health records, you must authorize their release through our Health Information Management (Medical Records) department.

(This page goes to patient - Do not scan into record)

Patient Identification

PeaceHealth
Detailed Message and Patient Communication Preferences

(This page goes to patient – Do not scan into record)

PeaceHealth

Detailed Message and Patient Communication Preferences

DETAILED MESSAGE: You may leave a **message with medical information** on voice mail/answering machine at the following number(s) (complete all that apply):

Home _____ **Cell** _____ **Work** _____

FAMILY AND FRIENDS:
I give my permission for PeaceHealth to give information to the following individuals involved in my care:

_____
Name Relationship Phone
❑ May leave a message with another member of the household or leave a message on an answering machine.

_____
Name Relationship Phone
❑ May leave a message with another member of the household or leave a message on an answering machine.

_____
Name Relationship Phone
❑ May leave a message with another member of the household or leave a message on an answering machine.

ALTERNATE COMMUNICATION:
I understand I have the right to request that PeaceHealth communicate with me by alternative means or at alternate locations. We will accommodate all reasonable requests. All e-mail will be sent through your **My PeaceHealth** account.

I wish to receive communication of my Protected Health Information from PeaceHealth by the following means: _____

I acknowledge that I have been presented with a copy of the Detailed Message & Patient Communication Preferences information sheet. I understand this form is optional and does not expire. This request will be in effect until you notify PeaceHealth of a change.

_____
Signature Patient/Person Authorized to Sign for Patient - Relationship Date Time

_____
Printed Name

Patient Identification

Alt Communication