NEUROSURGICAL ASSOCIATES OF TAMPA BAY

603 7TH STREET S., SUITE #540, ST. PETERSBURG, FL. 33701 • PHONE: (727) 828-8400 FAX: (727) 828-8401

Thomas J. Stengel, M.D. • Kirk W. Jobe, M.D. • Cedric D. Shorter, M.D. • Adam R. Befeler, M.D.
Jennifer M. Wallace, PA-C • Casie J. Parker, PA-C

Welcome! You may return the forms in person, fax, or our secure office email to info@nsatb.com. **Please write in black ink only.** In order to provide the best possible care, we require that all scans be no older than **six months** from the date of your appointment. Our providers are proud to be a part of the trauma teams at Bayfront Hospital, St. Anthony's Hospital, and Northside Hospital and as a part of that team may be required to perform emergency surgery during the time of your appointment. We will be as accommodating as possible to work around these scenarios if they arise and appreciate your understanding in this matter. Free Valet is available every day in front of our building. Free Self-parking in the attached parking garage and metered parking are also available. *We look forward to offering you the best possible care!*

First Name: _____ **Middle Initial**: ___ **Last Name:** _____ **Date of Birth:** ___/___/____
S.S. #:_____ **Marital Status:** _____
Race: _____ **Ethnicity**: _____ **Language**: _____
Address: _____
Phone Home: _____ **Cell:** _____ **Work**: _____
Email _____
Out of Town Address: _____
Emergency Contact: _____ **Emergency Phone:** _____
Primary care Physician: _____ **Phone**: _____
Referring Physician: _____ **Phone**: _____
Pharmacy: _____ **Phone#**: _____
Primary Insurance: _____ **Policy#:** _____
Secondary Insurance: _____ **Policy#:** _____

Worker's Compensation/Auto Accident/Personal Injury Information (IF APPLICABLE)

Name of Employer: _____ Phone#:_____
Date of Accident: _____ Place: _____ State:_____
Name of Insurance Carrier: _____ Phone#:_____
Date of Injury: _____ Date First Treated: _____
Date Patient Unable to Work in Current Occupation: _____
Claim Number: _____
Adjuster Name: _____ Phone#:_____
How Did Accident Happen? _____

Attorney Information* (IF APPLICABLE)

*This is for information purposes only. Please note that we do not accept Letters of Protection (LOP) nor do we wait until a case is settled before expecting payment. Please refer to our Financial Policy for further information.
Attorney Name: _____
Address:_____
Phone#:_____ Fax#:_____

HEALTH ASSESSMENT FORM

Completion of this form helps to provide your physician with a detailed medical history.
Height: _____ Weight: _____ ☐ Right Handed ☐ Left handed
Occupation (if retired, previous occupation): _____
What is the problem you would like us to help you with today? Describe your symptoms.

_____

_____

When did your symptoms first start? _____Was it ☐ sudden or ☐ gradual?
What activities were you engaged in when your symptoms first started? _____

_____
Frequency of Symptoms: ☐ Constant ☐ Intermittent ☐ Daily ☐ Once per week ☐ Other: _____
Character of Pain: ☐ Burning ☐ Electric Shock ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Deep ache
☐ Other (please describe) _____
Aggravating Factors: (things that make the symptoms worse)
☐ Lifting ☐ Standing ☐ Climbing Stairs ☐ Movement of neck ☐ Coughing ☐ Walking ☐ Sitting in Car
☐ Straining of bowels ☐ Sneezing ☐ Sitting ☐ Arms overhead ☐ Other: _____
Alleviating Factors: (things that make the symptoms better)
☐ Walking ☐ Sitting ☐ Laying Down ☐ Leaning forward ☐ Ice pack ☐ Moist Heat
☐ Other: _____
How was the problem treated in the past? _____

PAST MEDICAL HISTORY:
Check if the patient has any of the following diseases currently or in the past.

Patient	Family	Disease
☐	☐	Heart Disease
☐	☐	Lung Disease
☐	☐	High Blood Pressure
☐	☐	Stroke/TIA
☐	☐	Diabetes
☐	☐	Ulcers
☐	☐	Seizures
☐	☐	Arthritis
☐	☐	Hernia
☐	☐	Peripheral vascular disorder
☐	☐	Autoimmune disorder/Lupus

Patient	Family	Disease
☐	☐	Cancer (type?)
☐	☐	Thyroid problem
☐	☐	Blood Disorder
☐	☐	Hepatitis
☐	☐	Kidney/bladder disorder
☐	☐	Gout
☐	☐	Mental/Nervous disorders
☐	☐	Liver disorder
☐	☐	TB
☐	☐	HIV
☐	☐	Fibromyalgia

PAST SURGICAL HISTORY: Please list any surgeries and the dates performed

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY:

Tobacco: Are you a☐ Current smoker ☐ former smoker☐ never smoker.

If 'current smoker': How many cigarettes a day do you smoke? ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 +

Alcohol: Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If 'Yes': How often did you have a drink containing alcohol? _____

Recreational Drugs: ☐ No ☐ Yes, What? _____ How Often? _____

Comments: _____

MEDICATION LIST:

(List all medications currently taking and over the counter/non-prescription) Please attach list if necessary

NAME	**DOSE**	**FREQUENCY**	**NAME**	**DOSE**	**FREQUENCY**

ALLERGIES: (List all allergies and reactions including medications, latex, iodine, contrast dye)

_____ _____

_____ _____

SYSTEMS REVIEW CHECK YES OR NO.

CONSTITUTIONAL SYSTEMS:

Good general health lately	☐ NO	☐ YES
Recent weight loss	☐ NO	☐ YES
Fever	☐ NO	☐ YES
Fatigue	☐ NO	☐ YES
Headaches	☐ NO	☐ YES

EYES:

Eye disease or injury	☐ NO	☐ YES
Wear glasses/ contact lens	☐ NO	☐ YES
Blurred vision	☐ NO	☐ YES
Glaucoma	☐ NO	☐ YES

EAR/NOSE/ MOUTH/THROAT:

Hearing loss	☐ NO	☐ YES
Earache or drainage	☐ NO	☐ YES
Chronic sinus/rhinitis	☐ NO	☐ YES
Nose bleeds	☐ NO	☐ YES
Mouth sores	☐ NO	☐ YES
Bleeding gums	☐ NO	☐ YES
Bad breath or bad taste	☐ NO	☐ YES
Sore throat or voice change	☐ NO	☐ YES
Swollen glands on neck	☐ NO	☐ YES

CARDIOVASCULAR

Heart trouble	☐ NO	☐ YES
Chest pain/ angina pectora	☐ NO	☐ YES
Palpitations	☐ NO	☐ YES
Shortness of breath	☐ NO	☐ YES
Asthma or wheezing	☐ NO	☐ YES

RESPIRATORY:

Chronic/ frequent cough	☐ NO	☐ YES
Spitting up blood	☐ NO	☐ YES
Shortness of breath	☐ NO	☐ YES
Swelling foot/ ankle/ hands	☐ NO	☐ YES

GASTROINTESTINAL:

Loss of appetite	☐ NO	☐ YES
Change in bowel movements	☐ NO	☐ YES
Nausea or vomiting	☐ NO	☐ YES
Frequent diarrhea	☐ NO	☐ YES
Painful bowel movements	☐ NO	☐ YES
Constipation	☐ NO	☐ YES
Rectal bleeding	☐ NO	☐ YES
Blood in stool	☐ NO	☐ YES
Abdominal pain/ heartburn	☐ NO	☐ YES
Ulcer stomach/duodenal	☐ NO	☐ YES

GENITOURINARY:

Frequent urination	☐ NO	☐ YES
Burning/ painful urination	☐ NO	☐ YES
Change in force of strain	☐ NO	☐ YES
Kidney stones	☐ NO	☐ YES
Sexual difficulty	☐ NO	☐ YES
Female- Pain w/ periods	☐ NO	☐ YES
Incontinent of urine	☐ NO	☐ YES
Dribbling	☐ NO	☐ YES

GENITOURINARY CONTINUED

Male- Testicle pain	☐ NO	☐ YES
Female- Irregular periods	☐ NO	☐ YES
Blood in urine	☐ NO	☐ YES
Vaginal discharge	☐ NO	☐ YES

# of pregnancies_____ # of miscarriages ____
Date of last Pap Smear_____

MUSKOSKELATAL:

Joint pain	☐ NO	☐ YES
Joint stiffness	☐ NO	☐ YES
Weakness	☐ NO	☐ YES
Back Pain	☐ NO	☐ YES
Cold extremities	☐ NO	☐ YES
Difficulty walking	☐ NO	☐ YES

INTEGUMENTARY:

Rash or itching	☐ NO	☐ YES
Change in skin color	☐ NO	☐ YES
Change in hair/ nails	☐ NO	☐ YES
Varicose veins	☐ NO	☐ YES
Breast pains	☐ NO	☐ YES
Breast lumps	☐ NO	☐ YES
Breast discharge	☐ NO	☐ YES

NEUROLOGICAL:

Headaches, frequent	☐ NO	☐ YES
Light headed or dizzy	☐ NO	☐ YES
Convulsions/ seizures	☐ NO	☐ YES
Numbness/ tingling	☐ NO	☐ YES
Tremors	☐ NO	☐ YES
Paralysis	☐ NO	☐ YES
Stroke	☐ NO	☐ YES
Head injury	☐ NO	☐ YES

PSYCHIATRIC:

Memory loss/confusion	☐ NO	☐ YES
Nervousness	☐ NO	☐ YES
Depression	☐ NO	☐ YES
Insomnia	☐ NO	☐ YES

ENDOCRINE:

Glandular problems	☐ NO	☐ YES
Hormone problems	☐ NO	☐ YES
Thyroid disease	☐ NO	☐ YES
Hot/cold intolerance	☐ NO	☐ YES
Skin dryness	☐ NO	☐ YES
Change hat/ glove size	☐ NO	☐ YES

HEMATOLOGIC/ LYMPHATIC:

Cuts slow to heal	☐ NO	☐ YES
Tendency to bleed/ bruise	☐ NO	☐ YES
Anemia	☐ NO	☐ YES
Phlebitis	☐ NO	☐ YES
Past transfusions	☐ NO	☐ YES

Authorization Signature I authorize Neurosurgical Associates of Tampa Bay to release information to the above insurance carriers regarding my medical care, and I hereby assign to Neurosurgical Associates of Tampa Bay all payments for services rendered to me. I understand that I am responsible for any amount not covered by insurance and have read the notice of privacy.

Signed/Acknowledged: _____ Date: _____