Neurological Center of NOVA
2050 Old Bridge Rd. #200
Woodbridge, VA 22192

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

Reason you are being treated today:

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

Neurological Center of NOVA

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: ____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Email: _____

Work Phone: (_____) _____-_____ ext_____

Cell Phone: (_____) _____-_____

Social Security Number: _____-_____-_____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth: _____/_____/_____

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Student Status: ☐ Full-time ☐ Part-time

RESPONSIBLE PARTY INFORMATION

If the patient is the person responsible for paying any out of pocket expense, please mark "self" and turn over to sign the Assignment and Release statement.

Patient's relationship to the responsible party: ☐ Self ☐ Spouse ☐ Child

Last Name: _____ First Name: _____ MI: ____

Street Address: _____

City: _____ State: _____ Zip: _____

Work Phone: (_____) _____-_____ ext_____

Social Security Number: _____-_____-_____ Sex: ☐ Male ☐ Female

Date of Birth: _____/_____/_____

Employment Status: ☐ Full-time ☐ Retired

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I authorize payment directly to Samad Oraee, M.D., PC of any medical/surgical benefits otherwise payable to me by my insurance carrier for services as described. Also, I hereby authorize the release of any information obtained in the course of my registration, interview, examination and treatment, necessary to file a claim with my insurance carrier(s) or deemed necessary pursuant to State or Federal law, statute or regulation.

NON-COVERED SERVICES

I accept responsibility for paying any monies not paid by my insurance carrier for a balance due, except that dollar amount which is limited by agreement between Samad Oraee, M.D., PC and the insurance carrier. Furthermore, I acknowledge that it is my responsibility to obtain any necessary healthcare care service plan authorizations/referrals before my visit takes place. Moreover, I agree that it my responsibility to contact my insurance carrier to confirm if Samad Oraee, M.D., PC is in my network and/or plan, before my visit takes place.

PRACTICE FINANCIAL POLICIES

I recognize that payment for all co-pays, deductibles, co-insurances and other pre-determined out of pocket expenses are expected at time of service. I acknowledge that it is my responsibility to know the amount of my out-of-pocket expenses and I agree to check with my insurance carrier before each visit to confirm any changes. I recognize that Samad Oraee, M.D., PC reserves the right to charge me for missed appointments and will bill my account for finance charges at the rate of 1.5% per month on my balance(s) after a period of 60days from the date of service. In the event that my account is placed in the hands of a collection agency or attorney for collection, I agree to pay all costs and expenses related to the collection thereof. A copy of my signature consenting to this agreement is as valid as the original, and shall continue to be valid for one year from the date of signature.

_____ _____/_____/_____

Patient/Responsible Party Signature **Date of Signature**

AUTHORIZATION FOR RELEASE OF CONFIDENTAL HEALTH CARE INFORMATION

Patient Name:	**Date of Birth:**	
Street Address:		
City:	**State:**	**Zip:**

This authorizes Dr.Samad Oraee to request and receive from the
Prescriber's Name
Virginia Department of Health Professions any and all records held by the Department relating to Schedule II-V controlled substances dispensed to the patient names above.

I understand that this authorization permits the Department of Health Professions to disclose confidential health care records to the prescriber named above. A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by law.

I understand that, if not previously revoked, this consent will expire one year after the date of my signature unless otherwise specified.

Patient Signature:	**Date:**
Guardian Signature:	**Date:**

NOTE: This authorization form is in addition to and separate from any other disclosure forms that you may have signed.

Neurological Center of Northern Virginia
Sam Oraee, M.D., Neurology and Pain management
Deborah Williams, RN, MSN, APRN, CNRN

2050 Old Bridge Road, Suite 200 Woodbridge, VA 22191 Phone 703 492-7626 Fax 703 492-7537
WWW.NeuroPainVIP.com ***Info@NeuroPainVIP.com***

MISSED APPOINTMENT POLICY

Dear Patient;

In an effort to serve you better and improve quality and efficiency we ask you to keep your scheduled appointments. In the event of an emergency or if you are unable to keep your scheduled appointment time, please call our office at least 24 hours in advance. All no shows and cancelled appointment outside of courtesy call period will be assessed a fee. This fee is not covered by insurance and will be your responsibility.

***New and follow up visit-$35 if not cancelled within 24 hours**
***NCS/EMG-$100 if not cancelled within 48 hours.**
***EEG/Video EEG-$100 if not cancelled within 48 hours.**

Thank you for your cooperation.

Sam Oraee, MD
Deborah William, APRN
Staff

Date: _____ Signature:_____