Pamela L. Vincent MD, P.C. – Riverwoods Neurological Center
New Patient History & Clinic Policies

To our patients; we appreciate the opportunity to be involved in your health care. Please help us provide excellent and efficient care by filling out this information form as completely as possible. If you are waiting for longer than 30 minutes after turning in your history forms, we apologize and please let the receptionist know.

Additional information you should know to help us provide the best medical care:

1. **Co pays / deductibles are always due at the time of service.**
2. **Please be prepared to provide current insurance information at each visit.**
3. Always bring a current list of your medications to your appointment and give it to the receptionist.
4. Medication refill requests can be left on the phone messaging service; we will generally call in refills after clinic hours; please allow at least 24 hours for refills.
5. Refill requests must be called in before noon on Friday to be filled before the following Monday.
6. Pain medication such as narcotics cannot be refilled early and cannot be refilled by the doctor on call.
7. Please be very careful not to run out of essential medications, such as seizure medications.
8. We rely on you to keep your scheduled appointments. You will be charged $35 for a missed appointment unless you notify us 24 hours in advance**.** This will be your responsibility, your insurance will not be charged. If you miss 3 appointments, we will not be able to reschedule another appointment.
9. If you do not pay your copay at time of service, you will be charged $15 on your next statement.
10. If you are asked to keep a symptom diary, obtain medical records, bring in test results, such as MRI scans, please remember to do so.
11. Our association with Integrated Healing Arts-Utah allows us to offer complementary and alternative approaches to management of some medical problems; if this is of interest to you, please request referral or more information.
12. Please let us know how we can better serve you and meet your expectations.
13. Finally, we ask for your patience as we are working with a new phone and computer system; if you can't get through to us, please keep trying or call the answering service @ (801) 491-1424.

Thank You

Pamela Vincent, MD and Staff

Pamela L Vincent MD, P.C.
Riverwoods Neurological Center

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Neurological Center New Patient History
Please fill out this form as completely as possible.

Patient Name ________________________ E-mail____________________________________

Date of Birth ____ Age ___________________

Referring doctor: ____________________ Primary Care Physician: _______________________

Are you right or left handed? _______________________________

Please describe the primary problem in detail,

___

___

___

When did the problem begin? ____

Are the symptoms changing? Getting worse ____________ Getting better _________
Are the symptoms constant ____
Do they occur in attacks? _______ If so, how often_____How long do they last? ___
Are there any other symptoms which are associated with this problem?
If yes, please explain ____
Is there anything that helps this problem? _________________________________
Is there anything which aggravates this problem? _____________________________

Have any tests been done to evaluate this problem? Please list, with dates and results, if known.

CT/MRI scans ____
X-rays ____
Blood tests ____
EEG ____
EMG/NCS ____
Lumbar Puncture ____
Other ____

___

What treatments have been prescribed? ______________________________________

What treatments have you tried on your own? ________________________________

Do you have any other comments? ____

Have you tried alternative/complementary methods of treatment? Please explain,

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Are you interested in exploring alternative/complimentary treatments? ____________

***Review of Systems:* Circle any positives and give details.**

1. General: fever, sweats, weight loss/gain, fatigue, swelling
2. Skin: ____
3. HEENT: ______________________________________
   Eyes: vision change
   Ears, nose, throat, tinnitus, vertigo, allergies
4. Neck/ back: pain, stiffness
5. Respiratory: asthma, cough, shortness of breath, sleep disorder
6. Breast pain, mass, nipple discharge
7. Cardiovascular: chest pain, syncope/fainting, hypertension
8. Gastrointestinal: abdominal pain, change in bowl habits, nausea, vomiting
9. Genitourinary: UTI, urinary incontinence, pelvic pain, blood in urine, change in urine stream
10. Musculoskeletal: joint pain, joint stiffness, muscle pain or weakness
11. Neurological: cognitive dysfunction, difficulty with speech or swallowing, numbness or tingling, focal weakness, headache, tremor, dizziness, vertigo, seizures
12. Psychiatric: depression, anxiety, mood swings
13. Endocrine: thyroid, diabetes, heat or cold intolerance, hair loss, excessive thirst
14. Heme/blood disorders, bruising
15. FMS
16. CFS

Past Medical History

***Allergies to Medications**?* Yes No

Please give details ____

Have you traveled out of the area recently? Where ________________________________
Have you had any known exposure to toxins, insect bites, or sick people? _______________

Family History

Has anyone in your family (biological / blood related) had one of these conditions?

Heart disease ___________________
Hypertension ___________________
Kidney disease _________________
Lung disease ___________________
Cancer ________________________
Diabetes _______________________
Thyroid disease _________________
High cholesterol _________________
Arthritis _______________________
Alcohol/Substance abuse ________

Neurological disease ___________________
Epilepsy _____________________________
Migraine/Headache ____________________
Stroke ________________________________
Dementia _____________________________
Developmental delay/ LD _______________
Parkinson's disease ____________________
Multiple Sclerosis _____________________
Psychiatric/ Psychological disease _______
Other ________________________________

Please indicate if you have a history (present or past) of other medical conditions.

Heart disease ____
Hypertension/ High blood pressure ____
Lung disease/ asthma ____
Sinus disease ____
Gastrointestinal disorder ____
Liver disease ____
Urinary / Kidney ____
Infectious disease ____
Endocrine/ thyroid/ diabetes ____
Cancer ____
Arthritis, if so, what type ____
Spine injury ____
Head injury ____
Psychiatric/ Psychological ____
Developmental delay/ learning disabilities _______________________________________
ADD/ ADHD ____
Alcohol / drug abuse ____
Neurological disease, specify ____
Headache ____
Stroke ____
Epilepsy/ seizures ____
Multiple sclerosis ____
Tremor ____
Movement disorder ____
Nerve or muscle disease ____
Other, please specify ____

Past Surgical History

If you have had surgery, please describe _____________________________________

Social / Personal History

Marital status: Married ________ Single ________ Divorced _______ Widow _______
Do you have children? ____
Are you employed outside the home? ____
Education: What is the highest grade completed? _______Are you currently in school___
How are things going in your personal life, at home and work? _____________________
Were there significant stressors during your childhood? ___________________________

Smoke cigarettes? ____
Drink alcoholic beverages? ____
Use recreational drugs? ____
Drink caffeinated beverages? ____
Exercise regularly? ____

Medications

Please list drug name, dose, and how long you have been taking. Please include OTC medications, supplements, herbs and homeopathic treatments.