

Today's Date: \_\_\_\_\_

Revised 02/06/2012/ttb

**PATIENT INFORMATION**

Social Security #: \_\_\_\_\_

DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone#: \_\_\_\_\_

Work #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Sex (circle one) Female Male

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Marital status: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Employer: \_\_\_\_\_

**In case of emergency, please contact:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home #: \_\_\_\_\_

Other #: \_\_\_\_\_

**Referral Information**

Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Certain situations require us to release records to the referring/treating physician. Would you like us to forward our physician's notes to your \_\_\_\_\_ referring physician and/or your \_\_\_\_\_ family physician? Initials: \_\_\_\_\_**

**MEDICAL SUMMARY**

**Medical Allergies:** \_\_\_\_\_

Major Illnesses: \_\_\_\_\_

**CONSENT TO TREAT**

I understand that I have presented myself to NeuroSpine Surgical Consultants for evaluation and/or treatment of my Neurological or Spinal condition. I am aware that I may require necessary treatment during my episode of care. I further understand that all options will be discussed prior to the administration of such treatments.

Patient's signature: \_\_\_\_\_

**INSURANCE INFORMATION**

Were you injured while working?

\_\_\_\_ Yes \_\_\_\_ No Date of Injury: \_\_\_\_\_

Is your visit related to an automobile accident?

\_\_\_\_ Yes \_\_\_\_ No Date of accident: \_\_\_\_\_

**Medical insurance Carrier**

Primary: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Insured's name: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Secondary: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Insured's name: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

\*We will need to make copies of all insurance card(s) and a photo ID.

I authorize the release of any and all medical information necessary for my medical care and to process medical claims. I understand that all fees incurred in the course of my treatment by NeuroSpine Surgical Consultants and/or it's authorized agents are my responsibility. I hereby authorize the insurance companies to make payment directly to NeuroSpine Surgical Consultants for those fees I have not previously paid. Additionally, I agree to all charges not paid by my medical insurance companies are ultimately my responsibility. I authorize the use of my signature on insurance submissions.

Responsible party name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I give authorization for NeuroSpine Surgical Consultants' staff to contact the following person(s) and leave messages regarding appointments or test/surgery scheduling in the event I am unable to be reached at the number(s) I have provided.

Name and phone numbers: \_\_\_\_\_

**Notice: Any diagnostic films/CD's left behind in this office, will be disposed of after a year.**

Initials \_\_\_\_\_

Luis A. Mignucci, MD  
Omar Colon, MD



**NEUROSPINE**  
SURGICAL CONSULTANTS

## Patient History of Present Problem

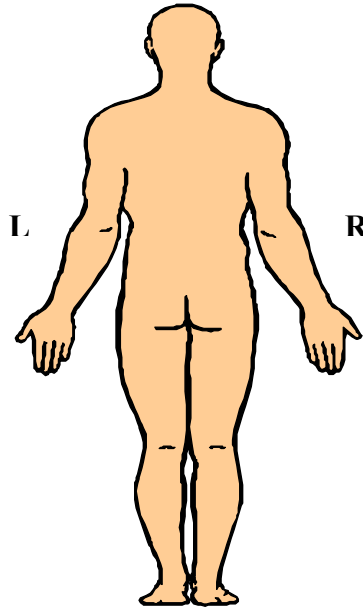
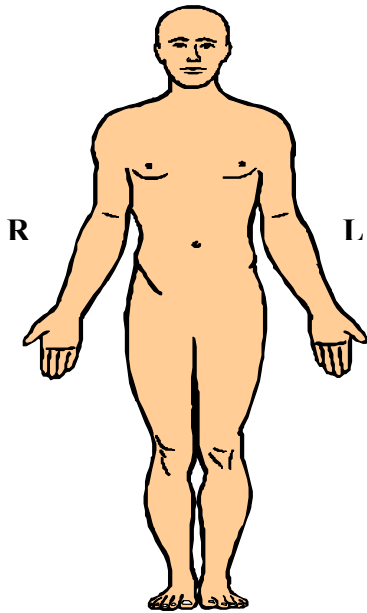
**Patient name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Age:** \_\_\_\_\_ **Race:** \_\_\_\_\_  R or  L handed **Sex:**  Male  Female

**In one sentence or less, please state the reason you are seeking a surgical evaluation:**

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Mark the areas on your body where you feel the described sensations by using the appropriate symbol.

**Ache:** ^^^^      **Numbness:** OOOO      **Pins & Needles:** == ==      **Burning:** XXXX      **Stabbing:** ////



Are you experiencing any of the following symptoms:

- Radiating pain
- Numbness (loss of sensation)
- Tingling
- Loss of control of bowels or bladder
- Weakness in arms or legs
- Gait changes
- Headaches
- Problems controlling your fingers

Please mark the level of your pain on the following scale:

0      1      2      3      4      5      6      7      8      9      10

**No Pain**

**Worst Possible**

Since their onset, have the symptoms:     Improved       Remained the same/leveled off       Progressively worsened

List two physical activities which aggravate your pain: \_\_\_\_\_

List two physical activities/positions which make the pain better: \_\_\_\_\_

Is the pain the result of an injury?  Yes     No     Unsure – please explain: \_\_\_\_\_

If this is an injury, is it:  Work related     Motor vehicle related     Other: \_\_\_\_\_

What is the date of injury? \_\_\_\_\_ If not an injury, date symptoms began: \_\_\_\_\_ Have you missed work because of your pain?  Yes  No If yes, how long? \_\_\_\_\_

Briefly describe how your injury occurred or how the symptoms began: \_\_\_\_\_

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When (date) did you begin to seek medical care for your symptoms? \_\_\_\_\_

Who did you seek treatment from (physician name/specialty): \_\_\_\_\_

Please list all other physicians you have sought treatment or opinions from:

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Patient name: \_\_\_\_\_

Please mark all diagnostics done with dates:  MRI \_\_\_\_\_  CT/Myelogram \_\_\_\_\_  Discogram \_\_\_\_\_

EMG/NVC \_\_\_\_\_  X-Ray \_\_\_\_\_  Other \_\_\_\_\_

What treatments have you tried to help alleviate your symptoms (please mark only those tried recently – in less than 2 years)

Physical therapy  Epidural Steroid Injections (ESI's)  Anti-inflammatory medication  Oral Steroids  Facet injections  Pain management program  Activity modification  Chiropractic adjustments  Other \_\_\_\_\_

### Medication Information

List all medications to which you are allergic:

\_\_\_\_\_  
Please list any medications you are currently taking (include over the counter and herbals). Please include dosages.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Past Surgical History

Starting with the most recent, please list in date order any **SPINE** surgeries you may have had:

|       |           |       |           |
|-------|-----------|-------|-----------|
| _____ | _____     | _____ | _____     |
| Date  | Operation | Date  | Operation |
| _____ | _____     | _____ | _____     |
| Date  | Operation | Date  | Operation |

Starting with the most recent, please list any other types of surgery you may have had:

|       |           |       |           |
|-------|-----------|-------|-----------|
| _____ | _____     | _____ | _____     |
| Date  | Operation | Date  | Operation |
| _____ | _____     | _____ | _____     |
| Date  | Operation | Date  | Operation |

### Family History

| Family Member       | Living                   | Deceased                 | Age   | Health Status or Cause of Death |
|---------------------|--------------------------|--------------------------|-------|---------------------------------|
| Mother              | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____                           |
| Father              | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____                           |
| Brother/Sister      | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____                           |
| Brother/Sister      | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____                           |
| Grandmother (mom's) | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____                           |
| Grandfather (mom's) | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____                           |
| Grandmother (dad's) | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____                           |
| Grandfather (dad's) | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____                           |

### Social History

**Marital Status:**  Single  Married  Divorced  Widowed  Separated

Occupation: \_\_\_\_\_ Do you have children?  Yes  No If yes, how many? \_\_\_\_\_

Do you live alone?  Yes  No If no, who lives with you? \_\_\_\_\_

Do you **smoke**?  Yes  No If Yes, how many packs per day? \_\_\_\_\_ For how long? \_\_\_\_\_

If you are a former smoker, how long ago did you quit? \_\_\_\_\_ How many packs per day were you smoking? \_\_\_\_\_

Do you drink **alcohol**?  No  Rarely  No, but I used to  Yes, daily  Yes, 1 or more times a week  Yes, socially

Are you at risk for AIDS (e.g. sexual orientation, history of drug use, previous blood transfusion)?  Yes  No



Medication Prescription and Refill Policy For  
Luis A. Mignucci, M.D.  
Omar Colon, M.D.

As a reminder to our patients, this is a surgical practice. It is not our practice to provide pain management medications to patients who have not undergone a surgical procedure performed by this office. Pain medications will be prescribed in the immediate post-operative period only. Use of pain medications beyond the immediate post-operative period will need to be managed by a pain management specialist.

Refill requests for medications prescribed by our office will be accepted **only from your pharmacy** during our regular business hours which are Monday thru Friday from 9:00 am to 5:00 pm. If you need a refill on your medication, you must call the refill request into the pharmacy at which it was originally filled. **Do not call the office** directly as this will only delay the process. If your request is received after 2:00 pm Monday-Thursday, or after 12:00 pm on Friday, it will be processed the next business day. **Absolutely no refills will be authorized on Saturday or Sunday.**

I have read and understand the above policy.

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Patient Name (Printed)

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Patient Signature  
2/9/12/tb

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Date

## Health History/Review of Systems

Have you had or been told you have any of the following conditions or symptoms? Please check all that apply.

### General

- Recent weight gain
- Recent weight loss
- Loss of appetite
- Recent Fever**
- Recent fatigue
- Recent night sweats
- HIV**

### Eyes, Ears, Nose, Throat

- Frequent headaches
- Migraine
- Head Injury
- Vertigo
- Light headedness
- Visual loss
- Double vision**
- Wear glasses/contact lenses
- Hearing loss
- Ringing ears
- Ear Drainage**
- Frequent nose bleeds
- Mouth sores
- Bleeding gums
- Toothaches
- Frequent sore Throat
- Hoarseness
- Voice changes
- Neck swelling
- Neck stiffness\Any other disorder of the eyes, ears, nose or throat

### Respiratory

- Shortness of breath with activity
- Shortness of breath while lying flat**
- Shortness of breath awaking you at night
- Wheezing**
- Chronic cough
- Coughing up blood
- Pleurisy
- Asthma**
- Chronic bronchitis**
- Emphysema**
- TB**
- Any other chronic respiratory disorder
- Date of last chest x-ray \_\_\_\_\_

### Cardiovascular

- Chest pain or tightness**
- Palpitations
- Irregular heart beat
- Rheumatic fever
- Heart murmur
- Heart attack**
- Swelling in ankles
- High blood pressure**
- Pain in calves when walking

- Phlebitis
- Blood clots
- Any other disease or disorder of the heart or blood vessels
- Date of last EKG \_\_\_\_\_

### Gastrointestinal

- Difficulty swallowing
- Frequent nausea/vomiting
- Vomiting of blood
- Abdominal pain
- Colic
- Jaundice**
- Frequent Diarrhea
- Chronic constipation
- Black, tarry stools**
- Bloody stools**
- Change in bowel habits
- Hemorrhoids
- Rectal pain
- Hernia
- Recurrent indigestion
- Ulcer**
- Pancreatitis
- Hepatitis**
- Gallstones
- Any other disease or disorder of the stomach, intestines or liver

### Genitourinary

- Pus or blood in the urine**
- Trouble starting to urinate
- Frequency
- Frequent walking to urinate
- Burning with urination**
- Incontinence
- Venereal disease
- Kidney stones
- Kidney or bladder infections**
- Kidney failure**

### Men only:

- Impotence
- Prostate problems
- Abnormal discharge from penis
- Vasectomy

### Women only:

- Abnormal Pap smear
- Bleeding between periods
- Breast lump
- Abnormal nipple discharge
- Painful intercourse
- Hysterectomy
- If not hysterectomy, are currently having regular menstrual cycles? \_\_\_\_\_
- If in menopause, or have had a hysterectomy, are you on hormone replacement therapy? \_\_\_\_\_
- Could you be pregnant?** \_\_\_\_\_
- Date of last menstrual cycle \_\_\_\_\_

### Skin

- Easy bruising
- Bleeding tendency
- Rash
- Itching
- Enlarged or painful lymph node
- Cyst
- Tumor
- Skin cancer
- Abnormal scarring
- Other disease or disorder of the skin

### Endocrine

- Sugar in the urine**
- Excessive urination
- Excessive hunger
- Excessive Thirst
- Temperature sensitivity
- Diabetes**
- Hyper-thyroidism
- Hypo-thyroidism
- Abnormal hormone levels
- Other endocrine disorders

### Musculoskeletal

- Joint pain
- Joint stiffness
- Weakness in arms
- Weakness in legs
- Fractures
- Deformity
- Amputation
- Rheumatism
- Gout

### Neurological

- Weakness
- Paralysis
- Atrophy
- Tremors
- Seizures
- Imbalance
- Numbness
- Tingling
- Transient ischemic attacks
- Stroke
- Multiple sclerosis
- Fibromyalgia

### Mental status

- Problem with relationships
- Sudden mood changes
- Hallucinations
- Delusions
- Depression
- Insomnia
- Drug addiction
- Claustrophobic
- Other mental disorder

*The information provided is accurate to the best of my knowledge.*

\_\_\_\_\_  
*Patient Signature & Date*

\_\_\_\_\_  
*Please print your name*

\_\_\_\_\_  
*I have reviewed the information provided by the patient. Physician Signature & Date*



**Luis A. Mignucci, M.D.**  
**Omar Colon, M.D.**

Dear \_\_\_\_\_

Thank you for choosing NeuroSpine Surgical Consultants for your medical needs.

Your appointment for a surgical evaluation has been scheduled for:

\_\_\_\_\_ at the following office location:

- 6160 Windhaven Parkway Ste. 200 Plano, Texas 75093 (972) 378-6908

**PLEASE READ CAREFULLY THE FOLLOWING INSTRUCTIONS:**

- **Physician Referral:** Some insurance companies require a referral from a primary care physician (PCP). Please contact your insurance company or PCP to determine if you need a referral. If your insurance is one that requires a referral, please obtain the referral and provide it to our office. The referral **must** be on file before our medical personnel can see you. **PLEASE BRING YOUR MEDICAL INSURANCE CARD(S) AS WELL AS A PICTURE ID (Driver's License) TO YOUR APPOINTMENT.**
- **Medical History Form:** Please complete the enclosed medical history form as completely and accurately as possible. Please include the name, strength and dose of **all medications.** Your past medical and surgical history should be as accurate as possible. **HAVING THIS PAPERWORK COMPLETED PRIOR TO YOUR APPOINTMENT TIME WILL HELP AVOID DELAYS IN SEEING THE DOCTOR.**
- **Diagnostic Films: (X-rays, CT Scans, MRI Films, etc):** In order for the surgeon to properly evaluate and determine your diagnosis, it will be necessary to review your most recent diagnostic films (X-rays, CT Scans, MRI films, etc). **PLEASE BRING THESE FILMS WITH YOU TO YOUR APPOINTMENT – YOU MUST HAVE THEM WITH YOU AT THE TIME OF YOUR APPOINTMENT OR YOUR APPOINTMENT WILL HAVE TO BE RESCHEDULED.** Films will not be accepted at our offices prior to your appointment time.
- **Medical Records/Office Notes:** It is also necessary for us to have your most recent medical records which relate to the condition necessitating this appointment. The last one or two office notes from your referring physician should be adequate.