MIDESSA
NEUROSURGERY & COMPLEX SPINE
Texas neurosurgery and spine destination

PATIENT REGISTRATION FORM

8050 E. HWY 191
Suite 250
Odessa Texas 79765

(432) 558-7000
(432) 214-2400
midessaneurosurgery.com

Patient Information

Last name | First name | Middle Initial | DOB

Age | Gender: ◯ Male ◯ Female | SSN

Marital status: ◯ Single ◯ Married ◯ Widow/Widower ◯ Divorced ◯ Separated ◯ Domestic Partner

Address | City | State | Zip Code

Cell phone | Home phone | Work phone | Email address

Name of Employer | Patient's occupation

Employment status: ◯ Full Time ◯ Part Time ◯ N/A

Student Status: ◯ Full Time ◯ Part Time ◯ N/A Name of School: _____

Spouse name | Spouse DOB

Race: ◯ American Indian or Alaskan Native ◯ African-American ◯ Asian ◯ White ◯ Hispanic ◯ Native Hawaiian

◯ Other: _____ *Federal regulations require us to ask your race/Ethnicity*

Ethnicity: ◯ Hispanic or Latino ◯ Non-Hispanic Languages spoken: ☐ English ☐ Spanish ☐ Others: _____

Driver's License # | Driver's License State

Emergency contact name | Emergency contact relationship | Daytime phone number | Evening phone number

Name of preferred local Pharmacy | Phone number of preferred local Pharmacy

Address of Pharmacy | City | State | Zip Code

Circle of Care

☐ Primary care provider	Office Phone	Fax Number	Location
☐ Referring Physician	Phone number	Fax Number	Location
☐ Cardiologist	Office Phone	Fax Number	Location
☐ Pain management	Phone number	Fax Number	Location

For Minors

Mother's name | DOB | SSN | Phone

Address | City | State | Zip Code

Father's name | DOB | SSN | Phone

Address | City | State | Zip Code

Insurance Information

Primary Insurance

Primary Insurance Company Name

Subscriber ID number | Group Number

Primary Card Holder ☐ Self ☐ Spouse ☐ Parent ☐ Others: _____

Name of policy holder | DOB of policy holder

SSN of policy holder

Secondary Insurance

Secondary Insurance Company Name

Subscriber ID number | Group Number

Primary Card Holder ☐ Self ☐ Spouse ☐ Parent ☐ Others: _____

Name of policy holder | DOB of policy holder

SSN of policy holder

Does your insurance require a referral for specialty visits? ◯ Yes ◯ No

If yes, do you have a referral for your visit? ◯ Yes ◯ No

Besides regular mail, I authorize Midessa Neurosurgery and Complex Spine to contact me by the following method:

☐ Cell phone ☐ Text messaging ☐ Home phone ☐ None

How did you hear about us?

☐ Physician/provider referral ☐ Family/Friend ☐ Website/Search engine ☐ Others: _____

☐ I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my Doctor of any change in my health and/or medication. Further, I will not hold my Doctor, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient / Representative

Name

Date

MIDESSA
NEUROSURGERY & COMPLEX SPINE
Texas neurosurgery and spine destination

MEDICAL HISTORY FORM

8050 E. HWY 191
Suite 250
Odessa Texas 79765

(432) 558-7000
(432) 214-2400
midessaneurosurgery.com

Patient Information

Last name | First name | Middle Initial

DOB: | Gender: ◯ Male ◯ Female

Welcome to our practice. Please take the time to fill out this form. This form is for our records only and will be considered confidential.

Reason for Visit

Chief Complaint | Duration of symptoms

If visit related to worker's compensation case? ◯ Yes ◯ No

Medications and Allergies

Current Medication and doses (including OTC supplements)

	Medication	Dosage	Frequency		Medication	Dosage	Frequency
1				6			
2				7			
3				8			
4				9			
5				10			

Pharmacy | Phone Number

Are you on any blood thinners? (Aspirin, Plavix, Eliquis, Coumadin, Pradaxa, Xarelto) ◯ Yes ◯ No

If yes, which one and what is the indication. _____

☐ I am allergic to Contrast dye. ☐ I am allergic to Gadolinium.

☐ I am allergic to Iodine. ☐ I am allergic to Latex.

Drug allergies including antibiotics and describe the allergic reaction

Past Medical History

Have you been hospitalized in the last 24 months? ◯ Yes ◯ No

If yes, explain: _____

Do you have or have a history of:	Y	N
Cardiovascular		
Chest pain/Heart Attack/Palpitations	◯	◯
Abnormal heart rhythm	◯	◯
High blood pressure	◯	◯
High cholesterol	◯	◯
Pulmonary		
COPD	◯	◯
Emphysema	◯	◯
Asthma	◯	◯
Sleep Apnea / CPAP use	◯	◯
HEENT		
Ear problem	◯	◯
Eye disorder	◯	◯
Gastrointestinal		
Hepatitis/Liver disease/gallbladder disease	◯	◯
Stomach ulcer/acid reflux	◯	◯
Colitis	◯	◯
Genito-Urinary	◯	◯
Kidney problem	◯	◯
Enlarged prostate	◯	◯
Endocrine		
Diabetes type 1 (childhood)	◯	◯
Diabetes type 2 (adult onset)	◯	◯
If yes, last HgA1c _____		
Thyroid disease	◯	◯
Immune system		
Auto-immune disorder	◯	◯
If yes, type: _____		
Rheumatoid arthritis	◯	◯
Tuberculosis	◯	◯
STD	◯	◯
History of infection after surgery	◯	◯

Do you have or have a history of:	Y	N
Nervous system		
Stroke	◯	◯
Headaches/migraine	◯	◯
Seizures/epilepsy	◯	◯
Musculoskeletal		
Osteoporosis/Osteopenia T-Score _____	◯	◯
Swollen ankle/ arthritis/ joint disease	◯	◯
Chronic pain syndrome	◯	◯
Hematologic		
Anemia (low blood count)	◯	◯
Bleeding disorder	◯	◯
Blood transfusion	◯	◯
Blot clots	◯	◯
Oncologic		
Cancer	◯	◯
If yes, name type: _____		
Psychological		
Depression	◯	◯
Anxiety	◯	◯
Bipolar disorder	◯	◯
Schizophrenia	◯	◯
Others		
Is there anything you wish to discuss with your surgeon privately?	◯	◯
Female patients only		
Are you or could you be pregnant?	◯	◯
If yes, Expected delivery date: _____		
Are you nursing?	◯	◯
Are you on birth control pills?	◯	◯
Estimated first menstrual period: _____		
Last menstrual period: _____		
Are you in menopause:	◯	◯

Please List Any Medical Problems that were not listed above

Past Surgical History

☐ **No Surgeries**

List all surgeries as well as procedures like cardiac stents you have had in the past

Surgeries	Date of Surgery	Age	Surgeon	Complications

Have you or a family member had an adverse reaction to general anesthesia? ◯ Yes ◯ No If Yes, please explain

Family History

List all conditions: for example Diabetes, High blood pressure, blood clot in leg or lung, Cancer etc. and who in your family has them

	Medical Condition	Family members		Medical Condition	Family members
1			9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8			16		

Social History

Height: _____ Weight: _____ ◯ Right handed ◯ Left handed ◯ Both

Tobacco
◯ No-never
◯ Yes-currently When did you start: _____ How many packs/day: _____
◯ Yes-in the past When did you start: _____ When did you quit: _____

Alcohol
◯ No
◯ Yes How many drinks/day: _____ How often do you drink: _____

Illicit drug abuse
◯ No
◯ Yes ☐ Marijuana ☐ Heroin ☐ Cocaine ☐ Amphetamines ☐ Others: _____

Have you ever had a problem with prescription medication (i.e. misuse, abuse, or addition): ◯ Yes ◯ No

If yes, which drugs: _____

Do you have high risk behaviors that can expose you to HIV, Hep B or Hep C? ◯ Yes ◯ No ◯ Not sure

Employment status _____ Occupation _____

Marital status _____ Number of kids _____ Immunization up to date? _____

Do you have any objections to receiving blood or blood products? ◯ Yes ◯ No

Do you have a living will ◯ Yes ◯ No

Do you have DNR (Do Not Resuscitate)? ◯ Yes ◯ No If Yes, Please Provide our office with a copy for your chart

Do you have Advance Directive? ◯ Yes ◯ No

If No, would you be interested in information regarding it? ◯ Yes ◯ No

Who do you live with? _____

Do you feel unsafe at home? ◯ Yes ◯ No ◯ Sometimes

Complete Review of systems

Do you have or have a history of:	Y	N
CONSTITUTIONAL		
Weight loss	◯	◯
Loss of appetite	◯	◯
Fevers	◯	◯
Chills	◯	◯
Sense of ill feeling	◯	◯
Fatigue / tired	◯	◯
EYES		
Blurred vision	◯	◯
Double vision	◯	◯
Changes in vision	◯	◯
EARS/NOSE/THROAT		
Hearing loss	◯	◯
Ringing in ears	◯	◯
Nosebleeds	◯	◯
Difficulty swallowing	◯	◯
Pain with swallowing	◯	◯
CARDIOVASCULAR		
Chest pain	◯	◯
Chest tightness	◯	◯
Abnormal beats	◯	◯
Lightheadedness	◯	◯
Fluid retention	◯	◯
RESPIRATORY		
Shortness of breath	◯	◯
Shortness of breath with exertion	◯	◯
Shortness of breath lying down	◯	◯
Shortness of breath at night	◯	◯

Do you have or have a history of:	Y	N
GASTROINTESTINAL		
Abdominal pain	◯	◯
Nausea	◯	◯
Vomiting	◯	◯
Vomiting blood	◯	◯
Black / tarry stools	◯	◯
Bright red blood from rectum	◯	◯
Constipation	◯	◯
Diarrhea	◯	◯
ENDOCRINE		
Heat or cold intolerance	◯	◯
Unexplained weight gain / loss Hair loss	◯	◯
GENITOURINARY		
Urinary frequency	◯	◯
Burning with urination	◯	◯
Blood in urine	◯	◯
Leaking of urine	◯	◯
Urgency	◯	◯
MUSCULOSKELETAL		
Joint pain	◯	◯
Muscle soreness	◯	◯
Swelling in arms / legs	◯	◯
Weakness	◯	◯
SKIN		
Suspicious or changing moles	◯	◯
Dryness / itching	◯	◯

Do you have or have a history of:	Y	N
NEUROLOGIC		
Headache	◯	◯
Numbness	◯	◯
Tingling	◯	◯
Difficulty thinking	◯	◯
Difficulty with walking	◯	◯
PSYCHIATRIC		
Depression	◯	◯
Anxiety	◯	◯

Do you have or have a history of:	Y	N
HEMATOLOGIC / LYMPHATIC		
Lymphadenopathy	◯	◯
Excessive bruising / bleeding Anemia	◯	◯
ALLERGIC I IMMUNOLOGIC		
Environmental allergies	◯	◯
Frequent infections	◯	◯

Fall risk Assessment

If over 65, have you had any falls in the past year? ◯ Yes ◯ No

If yes, ◯ 1 fall with injury ◯ 2 or more falls with injury ◯ 1 fall without injury ◯ 2 or more falls without injury

Do you have diabetes? ◯ Yes ◯ No if yes, what is your current HgA1c? _____

Have you had MI, CABG, or coronary artery disease? ◯ Yes ◯ No

If yes, please provide the name and office address of your cardiologist

Opioid Risk Tool

Mark each box that applies to you	Score (Female)	Score (Male)
Family history of susbtance abuse		
☑ Alcohol	☐	☐
☑ Illicit Drugs	☐	☐
☑ Prescription drugs	☐	☐
Personal history of susbtance abuse		
☑ Alcohol	☐	☐
☑ Illicit Drugs	☐	☐
☑ Prescription drugs	☐	☐
Age 16 to 45 years	☐	☐
History of preadolescent sexual abuse	☐	☐
Psychological condition		
☑ ADHD, obsessive-	☐	☐
✓ Compulsive disorder		
✓ Bipolar disorder		
✓ Schizophrenia		
☑ Depression	☐	☐
OFFICIAL USE ONLY **Total:**		

ADHD: Attention-Deficit / Hyperactivity Disorder

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at all sure	Several days	Over half the days	Nearly every day
1	Little interest or pleasure in doing things	◯	◯	◯	◯
2	Feeling down, depressed, or hopeless	◯	◯	◯	◯
3	Trouble falling or staying asleep, or sleeping too much	◯	◯	◯	◯
4	Feeling tired or having little energy	◯	◯	◯	◯
5	Poor appetite or overeating	◯	◯	◯	◯
6	Feeling bad about yourself— or that you are a failure or have let yourself or your family down	◯	◯	◯	◯
7	Trouble concentrating on things, such as reading the newspaper or watching television	◯	◯	◯	◯
8	Moving or speaking so slowly that other people could have noticed? Or opposite, being so fidgety/restless that you may have been moving more than usual	◯	◯	◯	◯
9	Thoughts that you would be better off dead, or of hurting your-self in some way	◯	◯	◯	◯

OFFICIAL USE ONLY **Total:**

Previous Treatment

Medications tried

	Medication	Dosage	Frequency		Medication	Dosage	Frequency
1				6			
2				7			
3				8			
4				9			
5				10			

Physical Therapy for this pain

Have you tried physical therapy for this problem? ◯ Yes ◯ No

Location of therapy

Duration of therapy

Improvement with therapy

Epidural steroid injection

Have you tried Epidural steroid injection for this problem? ◯ Yes ◯ No Date of last procedure: _____

Performed by: _____

Improvement of symptoms (even for few hours): ◯ Yes ◯ No

If yes, how long did the relief last: _____

Radiofrequency Ablation (Burning Nerves)

Have you tried Radiofrequency Ablation for this problem? ◯ Yes ◯ No Date of last procedure: _____

Performed by: _____

Improvement of symptoms (even for few hours): ◯ Yes ◯ No

If yes, how long did the relief last: _____

Other treatments tried

☐ None ☐ TENS unit ☐ Acupuncture ☐ Chiropractic ☐ Heat ☐ Ice ☐ Radiation (i.e. Gamma knife)

Did it provide any relief, even if temporary: _____

I have seen other doctors for my condition: ◯ Yes ◯ No Doctor's Name: _____

If yes, when and treatment offered: _____

I have had surgery before for the same type of problem: ◯ Yes ◯ No

If yes, what type of surgery, Physician who performed surgery: _____

I have had the following tests

☐ Plain X-Rays ☐ CAT scan ☐ MRI ☐ Myelogram ☐ Discogram ☐ EMG/NCV

☐ I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my Doctor of any change in my health and/or medication. Further, I will not hold my Doctor, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient / Representative

_____
Name

_____
Date

Save Print Reset