UPS Neurology Center
Alok Bhagat, M.D.
400 Medical Park Drive, Suite LL1
Dover, Ohio 44622
Phone: 330-364-2700 Fax: 330-364-2770

Patient Intake Form

Date _____

Name _____ DOB _____ Age _____

Sex: ☐ Male ☐ Female

Insurance Coverage(s) _____

Handedness: ☐ Right ☐ Left ☐ Ambidextrous

Local Pharmacy _____

Referring physician _____

Mail Away Pharmacy _____

Other physicians you would like a progress report sent to _____

Reason for Visit and Symptoms:	**For how long:**
1)	
2)	
3)	
4)	
5)	
6)	

Current Medications and Dosages

Please list allergies below.

UPS
UNION PHYSICIAN SERVICES

Neurological Testing

Have you had any of the following testing:	YES	NO	DATE	PLACE
1. MRI . brain/cervical/thoracic/lumbar	1. ___	___	_____	_____
2. CT - brain or chest	2. ___	___	_____	_____
3. EEG	3. ___	___	_____	_____
4. Carotid Ultrasound	4. ___	___	_____	_____
5. EMG	5. ___	___	_____	_____
6. LP (Spinal tap)/myeloaram	6. ___	___	_____	_____
7. Angiogram	7. ___	___	_____	_____
8. Sleep study - PSG/CPAP/MSLT	8. ___	___	_____	_____

PAST MEDICAL HISTORY

Have you had any of the following illnesses?

		YES	NO			YES	NO
Childhood illness:	Chicken pox	___	___	Endocrine:	Diabetes	___	___
	Measles	___	___		Thyroid problems	___	___
Neurological:	Stroke	___	___	Renal:	Kidney Failure	___	___
	Sleep Apnea	___	___	GI:	Ulcer	___	___
	Multiple Sclerosis	___	___	GU:	Kidney Stone	___	___
	Parkinson's Disease	___	___	Musculoskeletal:	Arthritis	___	___
	Neuropathy	___	___	Cardiac:	Heart Attack	___	___
	Epilepsy	___	___		Congestive Heart Failure	___	___
Pulmonary:	Asthma	___	___		High Blood Pressure	___	___
	Emphysema	___	___	Injuries:	Head/Neck Injury	___	___

Cancers: ☐ Breast ☐ Lung ☐ Colon ☐ Other _____

Other Illnesses _____

PAST SURGICAL HISTORY

Have you had any of the following surgeries?

	YES	NO		YES	NO
Appendectomy	____	____	Back Surgery	____	____
Tonsillectomy	____	____	Bypass	____	____
Hernia	____	____	Craniotomy	____	____
Hysterectomy	____	____	Carotid Endarterectomy	____	____

Other _____

FAMILY HISTORY

	ALIVE	DECEASED	AGE	CAUSE OF DEATH	MAJOR ILLNESSES
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Brother 2	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Sister 2	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

UNION PHYSICIAN SERVICES

Patient Intake Form (Cont)

SOCIAL HISTORY

Are you: (Check one) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Do you have children? ☐ Yes ☐ No If yes, how many? _____

Highest grade level completed _____

Occupation _____

Do you use any of the following? (Check all that apply)

	YES	NEVER	QUIT	TYPE	AMOUNT PER DAY
Drug(s)	_____	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	_____

FUNCTIONAL HISTORY

Do you have trouble performing on your own? (Circle all that apply)

Walking Bathing Dressing Household chores Personal Hygiene

Eating Standing Driving Balancing Check Book

How far can you walk before you have to sit/rest? _____

How long can you stand before you have to sit/rest? _____

Do you have trouble going up and down the stairs? ☐ Yes ☐ No

Do you have trouble living independently? ☐ Yes ☐ No

Do you need to use a cane, walker, or wheelchair? ☐ Yes ☐ No

Do memory problems cause poor interaction? ☐ Yes ☐ No

Are your symptoms:

	YES	NO	WHEN
Work related?	____	____	_____
Injury related?	____	____	_____
Did you retain a Lawyer?	____	____	_____
Did you stop working?	____	____	_____
Did you return?	____	____	_____