

Huron Valley Neurology
Brian Woodruff, M.D.
Olav Jaren, M.D.



24 Frank Lloyd Wright Drive
by L, Suite 2300•P O Box 444
Ann Arbor, MI 48106
T: (734) 930-5300 F: (734) 930-5630

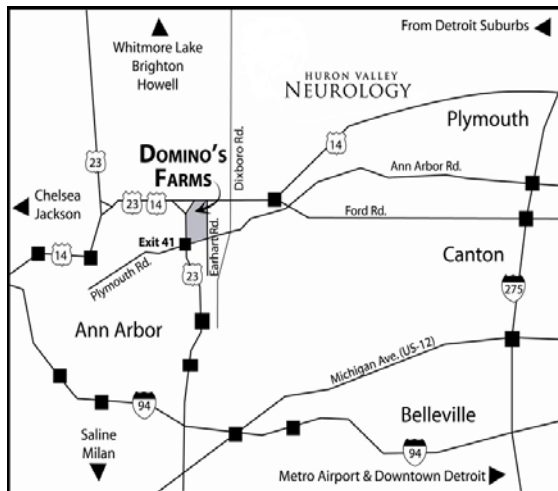
Thank you for choosing Huron Valley Neurology. Please fill the forms out completely and bring them with you to your appointment, along with your current insurance card(s). This will help expedite your waiting time in the office. Please arrive 15 minutes before your appointment time. This will allow our office enough time to register you.

We ask that you DO NOT bring any children to this appointment. Your appointment will be rescheduled if this is not possible. There is generally a great deal of information given at this appointment and this will allow you to devote your entire attention to your health care needs.

If you have an HMO or PPO insurance that requires a referral, please make sure we have it prior to your appointment or bring a copy with you.

Please call our office 24 hours in advance if you need to cancel. Failure to provide sufficient notification will result in a \$35 fee per appointment missed.

If you have any further questions regarding these forms or your appointment, please feel free to contact our office at 734-930-5300 or 1-877-313-6011.



Directions:

Coming South on US-23 exit at Plymouth Road – EXIT 41. Take a left and travel east .4 miles to Earhart Road and turn left. Continue to drive until you see LOBBY L. Parking is curbside in front of our new office. Our office is just inside the building on the right. Note the building entrance is on the 2nd floor, where our office is also located.

Coming North on US-23 exit at Plymouth Road – EXIT 41. Take a right and travel east .4 miles to Earhart Road and turn left. Continue to drive until you see LOBBY L. Parking is curbside in front of our new office. Our office is just inside the building on the right. Note the building entrance is on the 2nd floor, where our office is also located.

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Patient Name: _____

Date of Birth: / / Age: _____ Occupation: _____

Home Address: _____

Home Phone:() _____ Work Phone:() _____ Cell: () _____

Please check preferred number

Marital Status: (circle) Single Married Divorced Widow Partner

Email address: _____ Can be contacted by email? Y or N

Emergency contact _____ Relationship _____ Telephone: () _____

Primary Care Physician: First Name: _____ Last Name: _____

Address: _____

Office Phone: _____ Fax: _____

Is this a second opinion? YES NO

Other Neurologist(s) you have seen _____

Why are you being seen today? _____

What pharmacy do you use:

Name: _____ Phone: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Primary- Insurance Coverage

Insurance Company Name: _____

Name of subscriber: _____ Subscribers Date of Birth: / /

Contract Number: _____ Group Number: _____

Secondary Insurance

Insurance Company Name: _____

Name of subscriber: _____ Subscribers Date of Birth: / /

Contract Number: _____ Group Number _____

CURRENT MEDICATIONS: Please list all medications; including over the counter, vitamins, and supplements.

Medication (name & strength) Dosage Time(s) medication taken:

Do you believe that any of these medications are causing any side effects? YES NO

Past Medical History:

Please list all of your current and past medical conditions (example: high blood pressure)?

Test	Date:	Where:		Results:
MRI Brain	___/___/___	_____	Normal	Abnormal
CT Brain	___/___/___	_____	Normal	Abnormal
EEG	___/___/___	_____	Normal	Abnormal
Sleep Study	___/___/___	_____	Normal	Abnormal
List Other Tests	___/___/___	_____	Normal	Abnormal
	___/___/___	_____	Normal	Abnormal

Medication Allergies: Yes No

If yes: Medication Name: Reaction:

If you are female, are you pregnant? Yes No If yes, what is your expected delivery date? ___/___/___

If you are female, is there a possibility that you could be pregnant? Yes No

Have you had any surgeries?

Date (Month/Year): Reason:

Have you had any hospitalizations?

Date (Month/Year):

Reason:

Family History: (Please list for each person)

Mom:

Dad:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Siblings:

Children:

Social History

With whom do you live? _____

Do you Smoke? Yes No If yes, how many packs per day? _____

Do you consume alcohol? Yes No If yes, how much per week? _____

Have you experienced any of the following in the last 30 days?

	Yes	No		Yes	No
Weight loss If yes how much? ____ Over what period of time? ____			Insomnia Duration ____		
Fever? If yes ____F			Fatigue Duration ____		
Loss of Appetite			Back Pain		
Nausea			Rash		
Emesis (Vomiting)			Abdominal Pain		
Headache			Diplopia (double vision)		
Vision Loss			Shortness of Breath		
Bruise easily			Palpitations		
Syncope (passing out/fainting)			Cold Intolerance		
Urticaria (Hives)			Heat Intolerance		
Tremors					
Seizures					

Anything else **you** would like us to know, that it is not already covered in this questionnaire?
(Write on the back.)