

Huron Valley Neurology

Brian Woodruff, M.D.
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(734) 930-5300
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Note: If your child is having an EEG along with their appointment, please make sure they come with clean, dry hair.

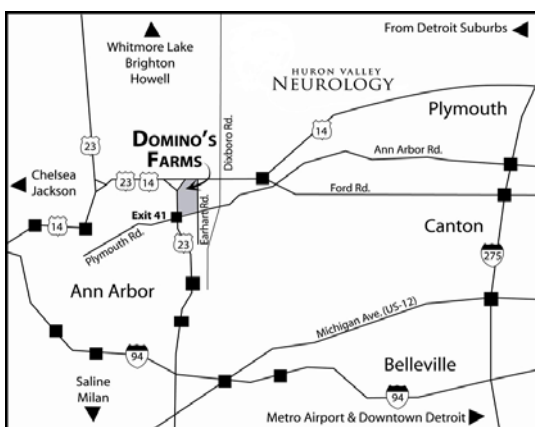
Thank you for choosing Huron Valley Neurology. Please fill these forms out completely and bring them with you to your child's appointment, along with your current insurance card(s). This will help expedite your waiting time in the office. Please arrive 15 minutes before your appointment time. This will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

We ask that you do not bring any siblings to this appointment. This appointment will be rescheduled if this is not possible. There is generally a great deal of information given at this initial appointment and this will allow you to devote your entire attention to your child's 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 child's appointment, please feel free to contact our office at 734-930-5300.



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 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.

HURON VALLEY NEUROLOGY



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Patient Name: _____ Date of Birth: ___/___/___

Age: _____ Sex: Male or Female

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone (____) _____ Work Phone (Mom) (____) _____ Cell (Mom)(____) _____

Work Phone (Dad) (____) _____ Cell (Dad)(____) _____
Email Address: _____ Can you be contacted by email? Y or N

Name of person filling out this form _____ Relationship _____

Mother's Name _____ Age _____ Occupation _____

Father's Name _____ Age _____ Occupation _____

Emergency contact _____ Relationship _____ Telephone _____

Primary Care Physician: First Name _____ Last Name _____

Address: _____

Office Phone: (____) _____ Fax: (____) _____

Other Neurologist(s) if seen _____ When? ___/___/___

Why is the patient being seen? _____

How do you hope that we will be able to help your child?

What pharmacy do you use:

Name: _____

Phone: (____) _____

Street: _____

Has your child had all the immunizations necessary for his or her age? Yes No
If no, please explain.

Is your child being treated for any chronic conditions? Yes No
If yes, please explain.

Do you have any concerns about pregnancy, labor, or the delivery of your child? Yes No
If yes, please explain.

Has your child's growth and developmental milestones been normal: Yes No
If no, please explain.

Has your child had any hospitalizations?

Date (Month/Year): Reason:

Has your child had any surgeries?

Date (Month/Year): Reason:

Family History: (check if yes)

	Seizures	Developmental Problems	Headaches
Mom			
Dad			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sibling(s)			

Social History

Hand dominance: (please circle) Right Left

With whom does your child live?

Is your child in special education classes or does he/she get special resources at school for learning?

Grade Level: _____ Name of School: _____

How has your child performed in school?

(Please circle one)

Below Grade Level

At Grade Level

Above Grade Level

Please list your child's brothers and sisters and their ages.

1 _____ 2 _____

3 _____ 4 _____

Has the Patient 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					

