NEURORADIOLOGY & PAIN SOLUTIONS OF OKLAHOMA

Dan TD Nguyen, MD
Amanda Garner, PA-C

Patient Demographics

First:_____ Last:_____ MI_____ Date of Birth_____/_____/_____ Sex _____

Gender Identity	Sexual Orientation	Race	Ethnicity
☐ Male	☐ Straight or Heterosexual	☐ White	☐ Not Hispanic/Latino
☐ Female	☐ Lesbian, Gay, or Homosexual	☐ Black/African-American	☐ Hispanic/Latino
☐ Female-to-Male	☐ Bisexual	☐ Native American/Alaskan Native	☐ Mexican
☐ Transgender Male	☐ Other: _____	☐ Pacific Islander or Native Hawaiian	☐ Central American
☐ Male-to-Female	☐ Choose not to Disclose	☐ Asian	☐ Puerto Rican
☐ Transgender Female		☐ Vietnamese	☐ Other: _____
☐ Choose not to Disclose		☐ Other: _____	☐ Choose not to Disclose

☐Single ☐Married ☐Widowed ☐Divorced SS#_____ Email: _____

Mailing Address: _____ City_____ State_____ ZIP_____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

*I hereby authorize confidential communications from the physician or staff of this office regarding my healthcare, lab work, test results, treatments, appointments, prescriptions, etc… to be received at any of the phone numbers listed above. I authorize to receive appointment text reminders. I authorize the staff to leave messages on the voicemail or with the individual who answers the phone at any of the above numbers.

Your Employer: _____ Address: _____ Phone: _____

How did you hear about us: ☐Facebook ☐DearDoc ☐Google/Internet ☐Magazine ☐Radio ☐Referred by: _____

*I authorize the following individuals (spouse, family members, and/or friend) to call the office on my behalf to verify the status of appointments, treatment plan, medications, and/or account information. These individuals may also pick up prescriptions and/or samples that I have requested.

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

I understand this authorization will remain in effect until I revoke the authorization in writing.

☐ Primary: Insured's Name: _____ DOB: _____ SS#_____

Insurance Co_____ Policy#_____ Group# _____

Address: _____ Phone: _____

Insured's Employer (if different than patient): _____ Relationship to patient: _____

☐ Secondary: Insured's Name: _____ DOB: _____ SS#_____

Insurance Co_____ Policy#_____ Group# _____

Address: _____ Phone: _____

Insured's Employer (if different than patient): _____ Relationship to patient: _____

COVERED BY WORKERS COMPENSATION? ☐ NO or ☐ YES, Date of Injury: _____

Description of Injury: _____

Treating Physician: _____ City: _____ Phone: _____

Employer at Time of Injury: _____ Contact Name: _____

Employer Address: _____ Phone: _____

Workers Comp Insurance Carrier: _____ Phone: _____

Address:_____ City: _____ State: _____ Zip: _____

Name of Adjustor: _____ Phone: _____ Fax: _____

Policy/Claim#_____ Group/TWCC# _____

I authorize Neuroradiology & Pain Solutions of Oklahoma to release any necessary medical information to insurance carriers concerning this illness/accident/injury and irrevocably assign to the doctor all payments for medical services rendered. I understand I am financially responsible for all charges whether or not they are covered by insurance.

_____ _____/_____/_____

Patient or Responsible Party Signature Date

Dan TD Nguyen, MD
Amanda Garner, PA-C

Patient Acceptance of Financial Responsibility

As a courtesy to you, we will bill your primary and secondary insurance carrier(s) if you provide ALL necessary information. However, you are ultimately responsible for all charges for services rendered. In addition, your insurance company may require an authorization or precertification for certain procedures, services, drugs and supplies that may be provided to you. As a courtesy, we will contact your insurance company for authorization for services; however, it is ultimately your responsibility to understand what your insurance policy covers and assure you have authorization for services.

- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office.
- Co-payments or deductibles toward procedures are the patient's responsibility and must be paid prior to the procedure. If payment is not received prior to a scheduled procedure, it will be postponed. We may charge a $150 fee for a missed procedure appointment.
- If you are not insured, or if the services provided are not covered by your insurance, you will be expected to provide payment in full for our services at the time they are rendered.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- In those instances where we have a participating provider agreement with your insurance company for an agreed upon negotiated rate for our services, an adjustment will be made in the amount of the difference between this rate and our normal fees at the time we receive payment from your insurance company. You will remain responsible for required co-payments, applicable deductible amounts and any services that are not covered by your insurance plan.
- If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- Your health plan may refuse payment of a claim for some of the following reasons:
    1. This is a pre-existing illness not covered by your plan
    2. You have not met your full calendar year deductible
    3. The type of medical service rendered is not covered by your plan
    4. The health plan was not in effect at the time of service
    5. You have other insurance which must be filed first

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies any claim for any of these or other reasons, our office cannot be responsible for this. It is your responsibility as the patient to pay the denied amounts in full.

Payment Plans: Dr. Dan TD Nguyen, MD has contracted with Legacy Medical Management, LLC (for commercial insurance) to collect all outstanding balances following payment by insurer. The billing office is willing to set up a payment plan if needed. If payments are missed two (2) consecutive months, your account will be turned over to an outside collection agency.

Workers Compensation Patients: We must have prior authorization to treat from either the employer or the insurance carrier agent. Should the employer or carrier subsequently deny validated workers compensation services, such charges will be the financial responsibility of the patient.

Missed Appointments: I understand that Neuroradiology & Pain Solutions of Oklahoma may, but is not required to, call me to confirmany upcoming appointments. I understand this is a courtesy and I am ultimately responsible to keep my office appointment. I understand that Neuroradiology & Pain Solutions of Oklahoma may charge a $25.00 for the first missed appointment fee and I will personally pay the fee for appointments missed and not changed or cancelled at least 48 hours prior to my scheduled appointment. A second occurrence is a $50.00 fee, a third occurrence the patient understands they will be dismissed from the practice. *The fee is charged to the patient, not the insurance company, and is due at the next office visit.

I (PRINT NAME): _____have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance carrier. I authorize Neuroradiology & Pain Solutions of Oklahoma to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ _____/_____/_____

Patient or Responsible Party Signature Date

Dan TD Nguyen, MD
Amanda Garner, PA-C

Form Completion Policy

Completing forms is a service that requires administrative time to pull the necessary records, the doctor's time to review the records and then additional time to complete the requested form(s).

The following forms will be assessed a minimum $30 fee for completion:

- Workers Compensation
- Letter of Condition
- FMLA
- Misc. Patient Requests*

*Abnormally lengthy or complicated requests may incur more time and costs, which will be considered on an individual basis at our discretion.

Disability paperwork will need to be submitted to your primary care physician. He or she can refer you to a physician who does Functional Capacity examinations, etc. if need be.

Instructions:

- Submit form requests well in advance of when needed. We will make every effort to complete forms within 7 business days; however, we cannot make any assurance of completion within the patient's time frame. Also note that it may take 3-5 days for mail delivery.
- Patient must complete all of his/her information on the form prior to giving the form to us.
- Patient must not complete any portion to be completed by the doctor or our office.
- Provide a stamped, addressed envelope to expedite mailing of completed forms.

Payment is required before completion of all forms.

By signing below, I attest that I have read and understood the above form completion policy.

_____
Printed Name of Patient

_____ _____/_____/_____
Patient or Responsible Party Signature Date

Dan TD Nguyen, MD
Amanda Garner, PA-C

Medical Records Release Form

Patient Name	Date of Birth

Address	Telephone

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below. I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

Limitations on the information you may release subject to this Release Form are:

1. Last two office visits (if applicable)
2. Radiological reports
3. Lab reports
4. _____

Release my protected health information to the following person(s) / entity:

Name: Neuroradiology & Pain Solutions of Oklahoma
Street: 14100 Parkway Commons Dr, Suite 102 Fax# 405-242-4007
City: Oklahoma City State: OK Zip 73134

The reasons or purposes for this release of information are as follows:

1. For evaluation and treatment of patient
2. For continuity of care
3. _____

Patient Signature (or parent, guardian or legal representative)

X_____ Date: _____

Print Name: _____ DOB: _____

Dan TD Nguyen, MD
Amanda Garner, PA-C

Acknowledgement of Review of Notice of Privacy Practice

I have reviewed or have had the opportunity to review Neuroradiology & Pain Solutions of Oklahoma's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I have received or understand I am entitled to receive a copy of this document.

_____ _____/_____/_____
Patient or Responsible Party Signature Date

_____
Printed Name of Patient (or Personal Representative)

Patient's Date of Birth: _____/_____/_____

If the signer is not the patient:

_____
Description of Personal Representative's Authority

Dan TD Nguyen, MD
Amanda Garner, PA-C

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This notice describes our privacy practices. We are required by law to protect the confidentiality of your medical information; provide you with this notice of our legal duties and privacy practices; and abide by the terms of our current notice of privacy practices. We may change this notice and our privacy policies at any time and have the revised notice and policies apply to all the protected health information we maintain. If we change our notice, we will post the new notice in our office where it can be seen. You have the right to request at any time a paper copy of our current notice, even if you have agreed to receive this notice electronically.

A. How the Practice May Use or Disclose Your Health Information

1. **For Treatment** We may use and disclose your health information to those involved in your treatment. For example, your information may be used by or disclosed to a physician or other health care provider in this practice. Because your physician in this practice is a specialist, we may request your primary care physician share your health information with us, and we may provide your primary care physician with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. We may also provide your information to laboratories, pharmacists, and other outside providers involved in your treatment.
2. **For Payment** We may use and disclose your health information to others for purposes of billing and collecting payment for treatment and services that we provide to you. For example, we may submit a bill to you or a third-party who is financially responsible for your treatment, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and the treatment or supplies used in the course of treatment. We may also disclose your health information to other health care providers to assist in their billing and collection efforts.
3. **For Health Care Operations** We may use and disclose your health information to perform activities that support this practice, such as cost-management and business planning activities, and activities that ensure the delivery of quality care. For example, we may engage the services of a professional (such as an accountant, auditor, or attorney) to assist us with compliance-related activities. If we do so, these professionals may review billing and medical files. We may also ask quality improvement personnel to review our charts and medical records to evaluate the performance of our staff. We may also disclose your health information to other health care providers to assist in their health care operations.

B. Disclosures That Can Be Made Without Your Authorization. There are situations in which we are permitted to disclose or use your health information without your authorization and without providing you with an opportunity to object. Provided below are descriptions of such situations.

1. **Public Health, Abuse or Neglect, and Health Oversight** We may disclose your health information to certain public health authorities (such as local and state health departments and the Centers for Disease Control and Prevention) that are authorized by law to collect information for purposes of reporting information about disease or injury; reporting vital statistics; investigating the occurrence and cause of injury and disease; and monitoring adverse outcomes related to food, drugs, biological products, or medical devices. For example, if authorized by law, we may disclose health information about a patient to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may also disclose a patient's health information to report reactions to medications, report problems with products, or notify people of recalls of products they may be using. We may also disclose your health information to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

   Oklahoma law requires physicians to report child abuse or neglect. Oklahoma law also requires physicians who have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report that information to thestate. We are permitted to disclose health information about a patient to a public agency authorized to receive reports of child abuse or neglect and to disclose information about a patient to report abuse or neglect of elders or the disabled.

We may disclose your health information to a health oversight agency in connection with certain "oversight activities" authorized by law. Examples of these activities include audits; investigations; inspections; surveys' licensure and disciplinary actions; administrative, civil, and criminal actions or proceedings; and other activities necessary for the government to monitor government programs, the health care system, and compliance with civil rights laws.

2. **Disclosures Required by Law** We may disclose information about you when disclosure is required by law.
3. **Legal Proceedings /Law Enforcement** We may disclose a patient's health information in the course of judicial or administrative proceedings in response to an order of a court (or an administrative decision-maker) or other appropriate legal process. Certain requirements must be met before we disclose your information under these circumstances. We may also disclose a patient's information if asked to do so by a law enforcement official if the information: (a) is released pursuant to legal process, such as a warrant or subpoena; (b) pertains to a victim of crime and the patient is incapacitated; (c) pertains to a person who has died under circumstances that may be related to criminal conduct; (d) is about a victim of crime, and we are unable to obtain the person's consent; (e) is released because of a crime that has occurred on our premises; or (f) is released to locate a fugitive, missing person, or suspect. We also may release a patient's information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.
4. **Workers' Compensation** We may use or disclose your health information in order to comply with laws and regulations related to workers' compensation and similar programs.
5. **Decedents** We may disclose a deceased patient's health information to (a) a funeral director when such disclosure is necessary for the director to carry out his or her lawful duties; (b) to a coroner or medical examiner to identify a deceased person or a cause of death; and (c) an organ procurement organization for cadaveric organ, eye, or tissue donation purposes, if the patient is a donor.
6. **Research** We may use or disclose your health information for research purposes when an institutional review board or privacy board has reviewed the research project, approved the research, and established protocols to ensure the privacy of your health information. We may also use a patient's health information in connection with certain activities preparatory to research and in connection with research on the protected health information of decedents.
7. **Government Functions** If you are in the military, we may disclose your health information to appropriate military command officers upon request. We may also disclose your information to federal officials (a) for national security and intelligence activities authorized by law and (b) for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

C. **Your Rights** You have the following rights regarding the protected health information maintained by this practice:

1. **Requested Restrictions** You have the right to request we restrict or limit how we use or disclose your protected health information for purposes of treatment, payment, or health care operations. You also may request we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care. We do NOT have to agree to the requested restrictions, but if we do agree, we will comply with your request except under emergency circumstances or when otherwise required by law to use or disclose your information in violation of your request. **To request a restriction**, please submit the following information in writing: (a) the information to be restricted; (b) what kind of restriction you are requesting (for example, on the use of information, disclosure of information, or both); and (c) to whom the restrictions apply. Please send the request to our Privacy Officer at the address provided at the end of this notice. You do not need to provide us with the reason for your request.
2. **Confidential Communications** You have the right to request we communicate with you about your health and related issues by alternative means or at an alternative location. For example, you may request we contact you at work rather than at home. We are required to accommodate only *reasonable* requests. **To request a restriction**, please submit the following information in writing: exactly how you want us to communicate with you and, if you are directing us to send communications to a particular place, the contact/address information. Please send the request to our Privacy Officer at the address provided at the end of this notice. You do not need to provide us with the reason for your request.
3. **Inspection and Copies of Protected Health Information** You have the right to inspect and/or receive copies of your health information that is maintained by this practice. Oklahoma law requires that requests for copies be made in writing. We ask that requests for inspection of your health information also be made in writing. Please send your request to ourPrivacy Officer at the address provided at the end of this notice.

We may ask that a narrative of your health information be provided rather than copies. However, if you do not agree to our request, we will provide copies. We are also permitted to refuse to provide some of the information you ask to inspect or be copied if the information: (a) is psychotherapy notes; (b) reveals the identity of a person who provided information under a promise of confidentiality; (c) is subject to the Clinical Laboratory Improvements Amendments of 1988; or (d) has been compiled in anticipation of litigation. We are also permitted to refuse to provide access to or copies of your health information in other limited situations, provided we arrange for a review of our decision onyour request. Any such review will be made by another licensed health care provider who was not involved in the decision to deny access.

Oklahoma law requires us to be ready to provide copies or a narrative of your health information within 15 business days of your request or, in many situations, within 15 business days of receipt of payment for such copies. We will inform you when your records are ready or if we believe access should be limited. If we deny access, we will inform you of our decision in writing. We are, under most situations, permitted to charge a reasonable fee for providing copies of medical records. Medical records will be billed to you at the Oklahoma State set price of $1.00 for the first page, and .50 cents for each additional page.

4. **Amendment of Health Information** You have the right to request an amendment of your health information maintained by this practice. Any such request must be submitted in writing to our Privacy Officer and must include the reason(s) that support your request for amendment. We will respond within 60 days of your request. We will deny your request if you fail to submit the request in writing (and/or include the reason(s) supporting your request). Additionally, we may refuse to allow an amendment if, in our opinion, the information in question is: (a) was not created by our practice, unless you supply us with a reasonable basis to believe that the person or entity that created the record is not available to amend the record; (b) is not part of our designated record set; (c) is not part of the records you would be permitted to inspect or obtain copies; or (d) is accurate and complete. If we refuse to allow an amendment, we will inform you in writing. If we deny your request, you are permitted to include a statement about the information at issue in your medical records. If we approve the request, we will inform you in writing; will allow the amendment to be made; and, upon a request from you to do so, will notify the relevant persons and entities named in your request with which the amendment needs to be shared.
5. **Accounting of Certain Disclosures** You have the right to request an accounting of disclosures made by this practice for purposes other than for treatment, payment, or health care operations, made pursuant to an authorization signed by you or your representative; or made to you or your representative. Please submit any request for an accounting to our Privacy Officer at the address provided at the end of this notice. In your request, specify the time period for which you are requesting an accounting (which may not be longer than six years from the date of disclosure). Your first accounting of disclosures within a 12-month period will be free. For additional requests within that period, we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request before any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits We may contact you by telephone, text reminders, mail, or all of the above, to provide appointment reminders, information about treatment alternatives, or other health-related benefits or services. If we contact you by telephone and no one answers the call, it is our practice to leave a message on the telephone answering machine.

E. Complaints If you are concerned that your privacy rights have been violated, you may contact our office at the address provided at the end of this notice. We request that all complaints be submitted in writing. You may also send a written complaint to the Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

F. Patient Authorization We will obtain your written authorization for uses and disclosures that are not identified in this notice or permitted by applicable law. If you choose to sign an authorization, you can later revoke that authorization in writing, to stop future uses and disclosures; however, any revocation will not apply to disclosures or uses already made or to disclosures made in reliance on your prior authorization.

G. Contact Information If you have any questions or complaints, or if you want to make a request pursuant to any of the rights described above, please contact our office at 14100 Parkway Commons Dr, Suite 102, OKC, OK 73134.

NEURORADIOLOGY & PAIN SOLUTIONS OF OKLAHOMA

Dan TD Nguyen, MD
Amanda Garner, PA-C

Pain / History Questionnaire, page 1

Patient Name: _____ DOB: _____ Age: _____

Reason for Visit: _____

Is your pain a result of a work-related injury? ☐ Yes (or) ☐ No

Is your pain a result of a motor vehicle accident? ☐ Yes (or) ☐ No

Date of accident or injury ☐ ____/____/_____ (or) ☐ Does Not Apply

Is there a lawsuit pending or have you hired an attorney? ☐ Yes (or) ☐ No

Name of Attorney: _____ (or) ☐ Does Not Apply

Does your pain regularly wake you from your sleep? ☐ Yes (or) ☐ No

When did your pain begin? _____

Describe the injury or cause of pain in your own words: _____

_____

_____

Please select the type(s) of pain you experience. (Check all that apply.)

☐ Constant	☐ Intermittent	☐ Periodic	☐ Frequent	☐ Occasional
☐ Burning	☐ Sharp	☐ Stabbing	☐ Dull	☐ Aching
☐ Pounding	☐ Shooting	☐ Other (Describe) _____		

Since your pain began, which of the following people have you consulted for treatment?

☐ Family Doctor/Internal Medicine	☐ Neurologist
☐ Acupuncturist	☐ Neurosurgeon
☐ Chiropractor	☐ Physical Therapist
☐ Orthopedist	☐ Occupational Therapist
☐ Psychiatrist	☐ Other: _____

Which of the following pain treatments have you tried?

Tried	Use		Tried	Use	
☐	☐	Ice/Cold	☐	☐	Brace
☐	☐	Heat	☐	☐	Psychotherapy
☐	☐	TENS Unit	☐	☐	Physical Therapy
☐	☐	Massage Therapy	☐	☐	Pain Pump
☐	☐	Exercise	☐	☐	Injections: _____
☐	☐	Spinal Cord Stimulator: ☐Medtronic ☐Abbott/St Jude ☐Boston Scientific ☐Other:_____			

Pain Indicators/Relievers

Activity	Makes Pain		Activity	Makes Pain	
Sitting	☐ Better	☐ Worse	Taking Medications	☐ Better	☐ Worse
Standing	☐ Better	☐ Worse	Applying Heat	☐ Better	☐ Worse
Lying Down	☐ Better	☐ Worse	Applying Ice	☐ Better	☐ Worse
Walking	☐ Better	☐ Worse	Massage	☐ Better	☐ Worse
Sneezing	☐ Better	☐ Worse	Pushing/pulling	☐ Better	☐ Worse
Straining/Coughing	☐ Better	☐ Worse	Bending/stooping	☐ Better	☐ Worse
Sleeping	☐ Better	☐ Worse	Other:_____	☐ Better	☐ Worse

Dan TD Nguyen, MD
Amanda Garner, PA-C

Pain / History Questionnaire, page 2

Please list **any surgeries** that you have had in the past.

Operations	Approximate Date
1.	
2.	
3.	
4.	
5.	

What diagnostic studies (X-rays, MRI's nerve studies, etc.) have you had?

****Please bring all imaging on a disk with you to your appointment. If you do not, your appointment may be rescheduled.****

Type of Study	Date	Doctor that Ordered	Location of Test
☐ Lumbar MRI	____________	________________	___________________________________
☐ Cervical MRI	____________	________________	___________________________________
☐ CT Scan	____________	________________	___________________________________
☐ Myelogram	____________	________________	___________________________________
☐ X-Ray	____________	________________	___________________________________
☐ Bone Scan	____________	________________	___________________________________
☐ EMG	____________	________________	___________________________________
☐ Discogram	____________	________________	___________________________________

Please list all medications you have tried or are currently taking.

Tried	Use	Medications (List Below)	What strength?	How often?	Since when?	Prescribed by?
☐	☐	________________________	__________	_____________	________________	____________________
☐	☐	________________________	__________	_____________	________________	____________________
☐	☐	________________________	__________	_____________	________________	____________________
☐	☐	________________________	__________	_____________	________________	____________________
☐	☐	________________________	__________	_____________	________________	____________________
☐	☐	________________________	__________	_____________	________________	____________________
☐	☐	________________________	__________	_____________	________________	____________________
☐	☐	________________________	__________	_____________	________________	____________________
☐	☐	________________________	__________	_____________	________________	____________________
☐	☐	________________________	__________	_____________	________________	____________________
☐	☐	________________________	__________	_____________	________________	____________________

Are you currently taking any of the following or other blood thinners? ☐No ☐Yes/ Prescribing Physician: _______________

☐ Coumadin (Warfarin) ☐ Plavix (Clopidogrel) ☐ Pradaxa ☐ Xarelto ☐ Eliquis ☐ Brilinta ☐ Other_________________

☐ Permission to access pharmacy record

Pharmacy Name:___________________________________ City: ________________________________ Phone: ____________________

DO YOU HAVE ALLERGIC REACTIONS TO ANY MEDICATIONS? (Please provide specific side effects.)

____

____

Please list any other allergies	**Reaction**
☐ Latex	
☐ Tape	
☐ Dyes/Contrast Media	
☐ Other: ______________________________	
☐ Other: ______________________________	
☐ Other: ______________________________	

NEURORADIOLOGY & PAIN SOLUTIONS OF OKLAHOMA

Dan TD Nguyen, MD
Amanda Garner, PA-C

Lifestyle Questionnaire

Date: _____ Name: _____

Please check all that apply:

☐ I am currently working.
☐ I am not currently working, but not due to pain problems.
☐ I am not currently working because of my pain.
☐ I am able to work, but at a reduced level and/or reduced hours because of my pain.
☐ I choose not to work.

Please describe your employment. Be specific about physical requirements and hours.

_____
_____

Please rate your pain level. (Circle appropriate number.)

(Lowest) 0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10 (Highest)

Have you ever had a substance abuse problem, emotional or nervous problem? ☐ Yes ☐ NoIf Yes, please elaborate.

_____
_____
_____

Have you ever seen a psychologist or psychiatrist? ☐No ☐ Yes, please explain reason(s) and outcome.

_____
_____
_____

Do you drink alcohol? ☐ No ☐ Yes If yes, how many drinks average? _____ ☐ Per day ☐ Per week

If no, did you drink in the past? ☐ No ☐ Yes If yes, how long since you last drank? _____

Do you drink alcohol to take away the pain? ☐ Often ☐ Sometimes ☐ Never

Do you smoke or use tobacco products? ☐ No ☐ Yes If yes, how many cigarettes or packs per day? _____

When did you start? _____ If you used to smoke, when did you quit? _____

Have you or do you smoke marijuana or use illicit drugs? ☐ No ☐ Yes

If yes, what kind and how often? _____

Do you exercise? ☐ No ☐ Yes If Yes, what type of exercise and how often?

_____

Family History

☐ Unknown

Father	☐ Hypertension	☐ Heart Attack/Stroke	☐ Diabetes Type 1/ Type 2	☐ Cancer: _____	☐ Other: _____
Mother	☐ Hypertension	☐ Heart Attack/Stroke	☐ Diabetes Type 1/ Type 2	☐ Cancer: _____	☐ Other: _____
Sibling 1	☐ Hypertension	☐ Heart Attack/Stroke	☐ Diabetes Type 1/ Type 2	☐ Cancer: _____	☐ Other: _____
Sibling 2	☐ Hypertension	☐ Heart Attack/Stroke	☐ Diabetes Type 1/ Type 2	☐ Cancer: _____	☐ Other: _____

Anything else we should know to aid in your care? _____

NEURORADIOLOGY & PAIN SOLUTIONS OF OKLAHOMA

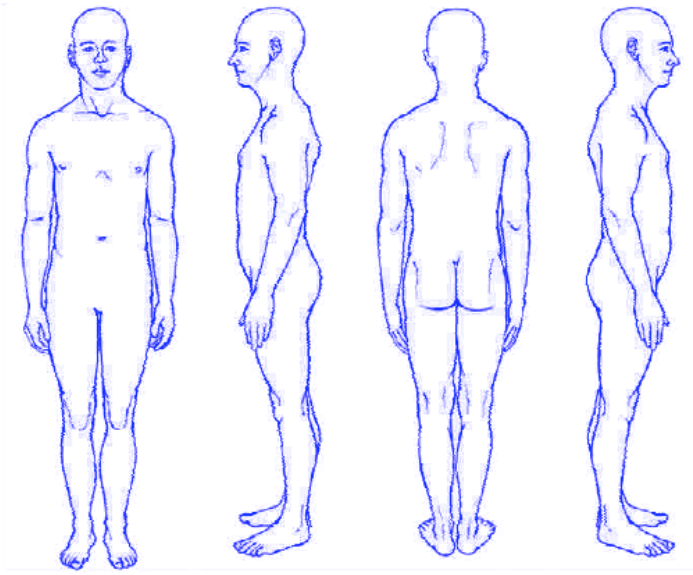
Dan TD Nguyen, MD
Amanda Garner, PA-C

Pain Diagram

Date: _____ Name: _____

Please mark the areas on the drawing where you feel your pain. Please use the appropriate letter(s):

N for Numbness **P** for Pins & Needles **B** for Burning **S** for Stabbing



Review of Systems

☐ Joint Stiffness	☐ weakness	☐ Pain in Neck	☐ Frequent Constipation
☐ Swollen Joints	☐ Seizures	☐ Pain in Shoulder	☐ Frequent Diarrhea
☐ Leg Cramps	☐ Loss of Strength	☐ Difficulty lying flat	☐ Blood in Stool
☐ Muscle Pain	☐ Balance Difficulty	☐ Swelling in Extremities	☐ Anxiety
☐ Muscle Cramp	☐ Difficulty Speaking	☐ Cold Extremities	☐ Depression
☐ Muscle Wasting	☐ Dizziness	☐ Palpitations	☐ Difficulty Sleeping
☐ Back Pain	☐ Paralysis	☐ Chest Pain	☐ Suicidal Thoughts
☐ Sciatica	☐ Shortness of Breath	☐ Irregular Heart Beat	☐ Headache
☐ Trauma to ankle	☐ Trauma to knee	☐ Heart Attack or Stroke	☐

Past Medical History:

☐ Hypertension ☐ COPD/Emphysema ☐ Sleep Apnea: On CPAP ☐Yes ☐No

☐ High Cholesterol ☐ Asthma ☐ Diabetes: ☐Type 1 ☐Type 2

Please list any additional past medical history: _____

_____

_____

_____