Neurology Headache and Pain Clinic
Sachin R. Shenoy, M.D.
Board Certified in Neurology and Pain Management

Patient name ___________________________ Date of birth ___________________ Male____ Female_____

Social security # ________________________ Home phone ________________ Work phone _______________

Cell Phone _____________________________ Best Phone # to call (please circle) Home Cell Work

Referred By (Please List): Physician __________________________ Friend_________ Family ________________

Heard about us from _____ Newspaper ____ Yellow Pages _______Radio _____ Internet ________

Mailing address ____ City_______________________

State __________ Zip ________________

Have you ever seen Dr. Shenoy prior to today for any medical reason? Yes / No

Employer ___________________________________

Local person to contact in case of emergency ___________________ Phone # ________________________________

Primary Insurance __________________________ Card Holders Name _________________________________

Secondary Insurance ____________________________ Card Holders Name _________________________________

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) (ALL PATIENTS MUST SIGN)

I acknowledge that I have been given the opportunity to read the Heath Insurance Portability and Accountability Act of 1996 (HIPAA), and I agree to the terms set forth. Please Note: If your copy is missing there is a copy on the wall to the left of the check in window.

X____

Signature of patient or parent if minor Date

AUTHORIZATION FOR US TO BILL MEDICARE FOR YOUR VISITS

I authorize payment of Medicare benefits to Sachin R. Shenoy MD, PA I authorize the release/transmission of pertinent medical information necessary to determine benefits. I realize that I am responsible for deductibles, co-payments, and non-covered expenses.

X ____

Signature of patient or parent if minor Date

AUTHORIZATION FOR US TO BILL YOUR COMMERCIAL OR SECONDARY INSURANCE FOR YOUR VISITS

I authorize payment of insurance benefits directly to Sachin R. Shenoy MD, PA and the release/transmission of pertinent medical information necessary to determine benefits. I am responsible for all charges not covered by insurance contracts, including co-payments, deductibles, non-covered services, and those determined by the insurance company to be above their usual and customary charges.

X ____

Signature of patient or parent if minor Date

Patient name____ Date__________

PLEASE DESCRIBE YOUR PROBLEM IN A FEW WORDS:

____

____

____

PAST MEDICAL HISTORY

Heart Disease No Yes
Diabetes No Yes
Migraines No Yes
High Cholesterol No Yes
Heart Attack No Yes
Epilepsy No Yes
Cancer No Yes If yes, please name type of Cancer ____
Any other Diseases No Yes Please List______________________________

High Blood Pressure No Yes
Arthritis No Yes
Thyroid Disease No Yes
TIA/ "mini stroke" No Yes
Depression No Yes
Stroke No Yes

PAST SURGICAL HISTORY

NO PRIOR SURGERIES ____ (Please proceed to next paragraph)

Tonsillectomy No Yes
Gallbladder removal No Yes
Heart Stents No Yes
Hip replacement No Yes
Cancer Surgery No Yes

Appendix removal No Yes
Heart Bypass No Yes
Leg Stents No Yes
Knee replacement No Yes
Pacemaker No Yes

For Female patients Hysterectomy No Yes
Ovaries removed No Yes

Brain Surgery No Yes If yes, date(s)__________Type of surgery done _________________________
Back Surgery No Yes If yes, date(s)__________ Type of surgery done _________________________
Neck Surgery No Yes If yes, date(s)__________ Type of surgery done _________________________
Please list any additional surgeries and date____

PERSONAL HISTORY

Marital Status: Single _____ Married _____ Divorced _____Widowed

Alcohol: Do You Drink Alcohol Never _____ Yes _____ Quit _____ Current __________
If In the past when did you stop, what and how much did you consume _____________________

Tobacco: Do You use tobacco Never _____ Yes _____ Quit _____ Current __________
If In the past when did you stop, what and how much did you consume _____________________

Illegal Drugs Do You use illegal drugs Never _____ Yes _____ Quit _____ Current __________
If In the past when did you stop, what and how much did you consume _____________________

FAMILY HISTORY

Father: ☐ Alive ☐ Deceased Major Illnesses ____
Mother ☐ Alive ☐ Deceased Major Illnesses ____
Brothers ____
Sisters ____
Children ____

Medications and dosage: (Please list all medications, dosages, and indicate how often you take the medication.)

1) ____

2) ____

3) ____

4) ____

5) ____

6) ____

7) ____

8) ____

Please List any allergies that you have

1.____

2.____

3.____

4.____

Please indicate any if you have had any of the symptoms mentioned below in the last three months by circling the yes response. If you have not had the symptom listed below please do not circle.

□ General Symptoms

Recent weight change	Yes
Fever	Yes
Fatigue	Yes
Headaches	Yes

□ Eyes

Eye disease	Yes
Injury to eyes	Yes
Blurred or double vision	Yes

□ Ears/Nose/Mouth/Throat

Hearing loss	Yes
Earaches	Yes
Chronic sinus problem	Yes
Nose bleeds	Yes
Mouth sores	Yes
Bleeding gums	Yes
Sore throat or voice change	Yes

□ Heart related

Chest pain	Yes
Palpitation	Yes
Shortness of breath	Yes
Swelling of feet or ankles	Yes
Swelling of hands	Yes

□ Lung related

Chronic cough	Yes
Spitting up blood	Yes
Shortness of breath	Yes
Wheezing	Yes

□ Stomach related

Loss of appetite	Yes
Nausea	Yes
Vomiting	Yes
Frequent diarrhea	Yes
Painful bowel movements	Yes
Constipation	Yes
Rectal bleeding	Yes
Blood in stool	Yes

□ Urination and Sexual symptoms

Frequent urination	Yes
Painful urination	Yes
Blood in urine	Yes
Incontinence	Yes
Dribbling	Yes
Kidney stones	Yes
Sexual difficulty	Yes
Male – testicle pain	Yes
Female – pain with periods	Yes
Female – irregular periods	Yes
Female – vaginal discharge	Yes
Female - # of pregnancies ____	

□ Muscle and joint related

Knee pain	Yes
Hip pain	Yes
Joint stiffness	Yes
Muscle pain or Muscle cramps	Yes
Back pain	Yes

□ Skin and Breast

Rash or itching	Yes
Change in skin color	Yes
Change in hair or nails	Yes
Varicose veins	Yes
Breast pain	Yes
Breast lump	Yes
Breast discharge	Yes

□ Nervous system symptoms

Frequent recurring Headaches	Yes
Light headedness	Yes
Dizziness	Yes
Convulsions or seizures	Yes
Numbness or tingling Sensations	Yes
Tremors	Yes
Paralysis	Yes
Head injury	Yes

□ Psychiatric

Memory loss	Yes
Confusion	Yes
Nervousness	Yes
Depression	Yes
Insomnia	Yes
Suicidal thoughts	Yes
Violent thoughts	Yes

□ Hormone related

Excessive thirst	Yes
Heat intolerance	Yes
Cold intolerance	Yes
Skin becoming drier	Yes
Change in hat or glove size	Yes
Thyroid problem	Yes

□ Blood related

Slow to heal after cuts	Yes
Bleeding or bruising tendency	Yes
Anemia	Yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services I may need. I authorize Dr Shenoy and his staff to release to a physician/s of my choosing and to discuss my care with him/ her / them as needed. I also give Dr Shenoy permission to discuss my health issues with my prior treating physicians if needed. . I also authorize Dr Shenoy and or members of his staff to discuss my information as required by law with any law enforcement agency or other enforcement agencies if required by law.

______________________________ ______________________________
Signature of Patient or Parent or Legal Guardian **Date**

Sachin R. Shenoy, M.D.
Neurology, Headache, and Pain Management Clinic
1845 Jess Parrish Ct, Titusville, Fl 32796
Phone (321) 264-2011 Fax (321) 264-0442

Authorization To Release Medical Records

I, ____, do hereby consent and authorize

Dr. Sachin Shenoy to disclose to ____

information from my medical records relating to identity, diagnosis, prognosis, or treatment, including psychiatric disorders and substance abuse, results of HIV testing, diagnosis of Acquired Immune Deficiency Syndrome and diagnoses related to AIDS. I understand that the specific type of information to be released includes: medical records, x-ray reports, laboratory reports, admissions, consults, operative notes, and discharge summaries, and that the purpose or need for this disclosure is to continue medical care and/or provide information to the other parties as named above at my request.

_________________________________ _____________________________

Signature of patient, legal guardian, or Authorized representative

Date

________________________________ _____________________________

Social Security Number

Date of Birth

Phone _____ - _____ - _______

Fax _____ - _____ - _______

Attention _______________________

Sachin R. Shenoy, M.D.
Neurology, Headache, and Pain Management Clinic
1845 Jess Parrish Ct, Titusville, Fl 32796
Phone (321) 264-2011 Fax (321) 264-0442

Patient Request and Authorization To Release Medical Records

I, ____, do hereby consent and authorize

____ to disclose to Dr. Sachin Shenoy

information from my medical records relating to identity, diagnosis, prognosis, or treatment, including psychiatric disorders and substance abuse, results of HIV testing, diagnosis of Acquired Immune Deficiency Syndrome and diagnoses related to AIDS. I understand that the specific type of information to be released includes: medical records, x-ray reports, laboratory reports, admissions, consults, operative notes, and discharge summaries, and that the purpose or need for this disclosure is to continue medical care and/or provide information to the other parties as named above at my request.

__________________________________ __________________________________

Signature of patient, legal guardian, or Authorized representative

Date

__________________________________ __________________________________

Social Security Number

Date of Birth

Phone _____ - _____ - _______

Fax _____ - _____ - _______

Attention ________________________

Neurology, Headache, & Pain Clinic
Sachin R. Shenoy, M.D., PA
Board Certified in Adult Neurology and Pain Management

Patient Name: ____ Date:_____________________

If you have been on or tried any of the medications below, please circle. If a medication has worked for you in the past please indicate so it can possibly be tried again. Please also list side effects next to the medication if any are known.

Anti-Depressants
Amitriptyline (Elavil)
Clomipramine (Anafranil)
Bupropion (Wellbutrin)
Nortriptyline (Pamelor)
Desipramine (Norpramin)
Doxepin (Sinequan)
Impramine (Tofranil)

SNRI's
Duloxetine (Cymbalta)
Trazodone (Deryrel)
Venlafaxine (Effexor)
Milnacipran (Savella)
Nefazodone (Serzone)
Desvenlafaxine (Pristiq)

Non-Narcotic Analgesics
Acetaminophen (Tylenol)
Aspirin
Butalbital (Esgic, Fiorinal)
Midrin (Isometheptene)
Tramadol (Ultram)
Lyrica

Muscle Relaxants
Carisoprodil (Soma)
Cyclobenzaprine (Flexeril)
Metazalone (Skelaxin)
Methocaramol (Robaxin)
Tizanidine (Zanaflex)

Multiple Sclerosis
Tysabri
Avonex
Betaserone
Rebif
Copaxone
Methylprednisone

Sedative- Hypnotics
Alprazolam (Xanax)
Buspirone (Buspar)
Clonazepam (Klonopin)
Clorazepate (Tranzene)
Diazepam (Valium)
Lorazepam (Ativan)
Chlordiazepoxide hydrochloride (Librium)

MAO Inhibitors
Pheneizine (Nardil)
Tranylcypromine (Parnate)
Isocarboxazid (Marplan)

Narcotic Analgesics
Bupenorphine (Suboxone)
Codeine (Tylenol 3)
Butorphanol (Stadol)
Fentanyl (Duragesic)
Hydrocodone (Lortab,Lorcet)
Hydromorphone (Dilaudid)
Demerol
Methadone (Dolophine)
Morphine (MS Contin, Kadian)
Nalbuphine (Nubain)
Dolophine (Methadone)
Oxymorphone (Opana)
Oxycodone (Percocet)
Oxycontin
Propoxyphene (Darvocet)

Epileptic Medications
Phenobarbital
Levetiracetam (Keppra)
Phenytoin (Dilantin)
Carbamazepine (Tegretol)
Oxcarbazepine (Trileptal)
Lamotrigine (Lamictal)
Gabapentin (Neurontin)

SSRI's
Citalopram (Celexa)
Escitalopram (Lexapro)
Fluoxetine (Prozac)
Paroxetine (Paxil)
Sertraline (Zoloft)

NSAID's
Diclofenac Potassium (Cataflam)
Diclofenac Sodium (Voltaren)
Ibuprofen (Advil, Motrin, Nuprin)
Meloxicam (Mobic)
Naproxen (Naprosyn)
Naproxen Sodium (Aleve)

Beta-Blockers
Atenolol (Tenormin)
Carvedilol (Coreg)
Metoprolol (Lopressor)
Propranolol (Inderal)
Timolol (Blocadren)

Migraine Medications
Almotriptan Malate (Axert)
Dihydroergotamine (Migranal)
Eletriptan (Relpax)
Ergotamine (Cafergot)
Frovatriptan (Frova)
Naratriptan (Amerge)
Methysergide (Sansert)
Rizatriptan (Maxalt)
Sumatriptan (Imitrex)
Treximet
Topiramate (Topamax)
Valproic Acid (Depakote)

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