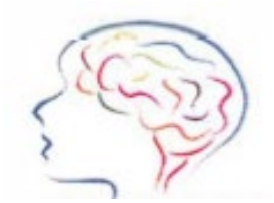

HAWAII PACIFIC DEEG

HONOLULU NEUROSCIENCE CLINIC

MICHAEL B. RUSSO, MD, FACP, FAAN, FAASM, FAsMA

HILO ____ HONOLULU ____ KONA ____

Today's Date:			Referring Doctor:		
PATIENT INFORMATION					
Patient's Last Name: First:			Sex: M F	Marital Status:	
D.O.B:	AGE:	Address:			
Social Security No.:		Home phone:	Cell Phone:		
Occupation:	Employer:		Employer Contact No.:		
Other family members seen here:		Email:			
INSURANCE INFORMATION (Please give your insurance card to the receptionist)					
Responsible Party:	Birth Date:	Address (if different):	Home Phone:		
Is this person a patient here? YES ☐ NO ☐		Is this person covered by insurance? YES ☐ NO ☐			
Occupation:	Employer:	Employer Address:	Employer Contact No.:		
Please indicate primary insurance:					
Primary Care Provider:					
Subscriber's Name:	Subscriber's SSN:	Birth Date:	Group No.:	Policy No.:	Copayment: $

The information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the phycisian. I understand that I am financially responsible for any balance. I also authorize MICHAEL B. RUSSO MD, to release any information to process my claim.

_____ _____

Patient/Guardian Signature Date

How did you hear about our Clinic? Online _____ Newspaper _____ Facebook _____ Friends _____

Magazine _____ Doctor _____ Other (please specify) _____

Your Name: _____ **Circle: Right or Left Handed** **Today's Date: _____** **Your Birhtdate: _____ Age: _____** **Your Doctor: _____** **Dr's Phone Number: _____**	**OFFICE USE ONLY** **DEEG POLY LABS VID AMB EEG** **EMG/NCV SLEEP PROFILER EEG** **MRI BRAIN C-SPINE L-SPINE ALICE HST** **Neupro 2mg / 4mg** **Exelon 4.6 / 9.5** **Trokendi 200mg** **Ambien 10 / 12.5** **Clonidine 600** **Trazodone 50 / 100** **Oxtellar 600** **Sumatriptan 6mg** **ASA 81mg / 325mg** **Temazepam 15/30**

PLEASE TELL US YOUR STORY- 1ST VISIT
(We want to get to know you)

What is your MAIN reason for seeing a neurologist today?

Describe your MAIN problem. (EXAMPLE: headache is pounding on the left side of my head and making me sick.)

When did this problem begin? (EXAMPLE: Childhood. Last week. Last month.)

Do you have any other nerve or muscle-related problems that are currently bothering you? (EXAMPLE: lower back pain, tingling in my feet and hands.)

Pain Assessment: Are you in pain today? YES ___ NO ___. If yes, where? _____
Using the scale below, make a mark to indicate how severe representing your pain right now. (If you are in pain)

1= NO Pain and 10= Most severe pain ever

1_____5_____10

List all medications currently taking or in the past.

C = Current take daily S = Sometimes take, if needed (PRN) P = PAST Took in the past not currently

C S P 1:_____
C S P 2:_____
C S P 3:_____
C S P 4:_____
C S P 5:_____
C S P 6:_____
C S P 7:_____
C S P 8:_____
C S P 9:_____
C S P 10:_____

HOSPITALIZATIONS and MEDICAL ILLNESSES.

Have you ever stayed as a patient in a hospital over night? Yes No
If yes, how many times?_____ For what conditions? _____
Circle any illnesses that you have: *Diabetes? High Blood Pressure? Heart Problems? Gastric distress? Liver problems? Kidney Problems? Past strokes? Blood clots? Others?*_____

HEADACHE QUESTIONS

Do you have any headaches? **Yes No** If *yes,* at what age did you get *your.first memorable headache?* ___ Ifyes:
How many days per month are you *completely headachefree?* (Circle below)
1-5 days? 6-10 days? 11-15? 15-20 days? More than 20 d$_{ay}$s per month without any headaches?
Are any of your headaches pounding or throbbing? **Yes No** Nausea? **Yes No** Light or sound sensitive? **Yes No**
What is the longest a headache has lasted? *Halfd$_{ay}$ Entire d$_{ay}$ More than one day Just a few minutes?*
Does your headache begin in a particular place in your head? *Front left side right side back of head around eyes?*
Do your headaches occur most often in: Morning, Afternoons, Evenings, Awaken you from sleep? **Yes No**
Have you ever gone to the Emergency Room for headaches? **Yes No**
What do you take or do to make your headaches go away? _____

SLEEP QUESTIONS

Do you feel that you sleep well?____ What time do you turn offthe lights?_____ Is the TV on? **Yes No**
Generally, how long does it take you to fall asleep? (Circle one)
5 Minutes or less 10-15 Minutes 15-30 Minutes 30-60 Minutes 60 Minutes or more
Do you sometimes take medicines to fall asleep? **Yes No** If yes, what medicines:_____
Do you have dreams?____Nightmares?_____ Sleep walk or talk?_____Do you use CPAP/BiPAP?_____
Do you snore? (or does bed partner say you snore?) **Yes No** Do you kick orjump around? **Yes No**
Do you grind your teeth or clench your jaw?_____
How many times do you awaken at night?_____ What wakes you up?_____Pets? Spouse snoring?
Do you awaken to an alarm clock? **Yes No** Are you sleepy during the days? **Usually No Sometimes**
Do you feel well rested and alert in the morning upon awakening? **Yes No**
What time is lights on?_____ .....What time do you actually get out of bed?_____
Do you drink Coffee, Tea, or Power Drinks in the morning to wake up? **Yes No**
Do you sometimes take a nap during the day? **Yes sometimes. Never**

EPWORTH SLEEPNESS SCALE

Over the **past month**, how likely are you to doze off or fall asleep in the following situations

(0= not a chance 1= possible, 2= likely, 3= high likelihood or have done so)

0 1 2 3 While sitting and reading?
0 1 2 3 While watching TV?
0 1 2 3 Sitting inactive in a public place, (Example: movies or meeting)
0 1 2 3 As a passenger in a car driving for an hour or so without a break?
0 1 2 3 Lying down in the afternoon nap permitted?
0 1 2 3 While sitting and talking to people?
0 1 2 3 While sitting quietly after lunch without alcohol?
0 1 2 3 While stopped in a car for a few moments at a stop light?

TOTAL SCORE (sum of all numbers) _____

FAMILY

Mother: Alive or Deceased (circle one) If Alive, What is current age?_____ Health?_____
If Deceased, What age, and From what condition?_____
Father: Alive or Deceased (circle one) If Alive, what is current age?_____Health?_____
If Deceased, what age, and from what condition?_____
Brothers, How many? _____ What ages_____ Sisters, How many? _____ What ages_____
What number child are you? _____ Youngest Sibling? (Sister Brother, Alive or deceased age?)_____
Does anyone in your family have an illness similar to what brings you in today? If yes, explain
Are you married (or have you been married?) **Yes No**
Do you have children? **Yes No** If yes, how many and what ages? _____

SOCIAL QUESTIONS

Do you use tobacco? **Yes No** If yes, what type and how often (EXAMPLE "I smoke a pipe 5 times a day")
How long have you been using tobacco?_____
Do you use any recreational drugs? (circle) Weed? Cocaine? Ice? Meth? Others:_____
Do you consume alcohol on a daily bases? **Yes No** If yes, what types of drinks and how much ?
(EXAMPLE, Mixed drinks, vodka, about 5 or 6 a day or, two beers per night _____
When do you have your 1st alcoholic drink? Morning___ Mid-day___ Afternoon ___ Night____ Pauhana_____
Do drink alcohol only with friends, or at parties, and not on a daily basis? **Yes No**
Do you exercise? **Yes No Sometimes** How often and for how long?_____
Have you ever had an alien encounter? **Yes No** if yes, when? _____

MEDICINE ALLERGIES:

List all Medicine allergies and what happens when you take the medicine (Example, makes me itch, hives, etc.)

If none, circle: *No medicine Allergies*

PAST MEDICAL HISTORY- SYSTEMS AND SYMPTOMS REVIEW

DO YOU HAVE or HAVE YOU HAD ANY OF THE FOLLOWING for MORE THAN ONE MONTH?

Generalized pain that will not go away
Fever
Chills
Night Sweats
Weight loss or gain
Nasal discharge
Lumps in neck or body
Pounding heart
Cancer
Diabetes
Arthritis
Thyroid
High or low blood pressure
Vaccinations
Neck Pain
Back Pain
Headaches
Stroke
Seizures
Heart Disease
Polio
Snoring
Shortness of breath while walking
Shortness of breath while climbing stairs
Pain when you breathe deeply
Cough that will not go away
Trouble eating or swallowing
Constant heartburn
Chronic Constipation
Genio-urinary symptoms
Denied frequent urges
Painful or excessive urination
Sexual difficulties, impotence
Unable to function

OFFICE USE ONLY

BLOOD PRESSURE:

PULSE:

RESPIRATION:

SpO2:

HEIGHT:

WEIGHT:

BMI:

VISION:

OD: 20/ ____

OS: 20/ ____

OD: 20/ ____

MEDICINE ALLERGIES:

DO YOU EVER FEEL LIKE HURTING YOURSELF?
IF YES- Do you feel that way right now? _____
IF YES- Who do you, or have you wanted to hurt? _____

Explain: _____

In general, how would you describe yourself? HAPPY SERIOUS ANGRY SLEEPY SAD (CIRCLE ONE)

Honolulu Neuroscience Clinic

Hawaii Pacific DEEG

Dr. Michael B. Russo, MD, FACP, FAAN, FAASM, FAsMA

Medical Director, Diplomat, American Board of Psychiatry and Neurology

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth**: _____

Phone H) _____ **Phone W)** _____

Address: _____ **City/State/Zip**: _____

Please note: Copy Fee May Be Charged for Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ Facility Phone:_____

Facility Address: _____ Facility Fax: _____

City/ST/Zip: _____

Dates and type of Information to disclose:

☐2 years prior from last seen

☐Dates Other: _____

☐Specific Information Requested:

_____

The purpose of disclosure is:

☐Change of Insurance or Physician

☐Continuation of Care (e.g., VA Med Ctr)

☐Referral

☐Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. This information may be disclosed and used by the following individual or organization:

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Release to: **Dr. Michael B. Russo, M.D.**

Address: **1335 Kalanianaole Ave.**

City, State, Zip: **Hilo, HI 96720** ☐Please mail records.

FAX: **808-748-2920** Phone: **808-294-3332** ☐Please fax records

I understand I may revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.
If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carried with it the potential for any unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I fI have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient/Parent/Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status)

Date

_____ _____

Printed Name of Authorized Representative

Relationship/Capacity to patient

_____

Address and Telephone number of Authorized Representative

Revised 11/2019 TJS

HONOLULU NEUROSCIENCE CLINIC

Michael B Russo M.D.
250 Ward Avenue 170 Honolulu, HI 96814-4016
Phone: (808) 294-3332 Fax: (808) 748-292

PATIENT HIPAA COMMUNICATION FORM

Disclosure to Self and to Others

Patient Name:_____ Patient DOB:_____

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have a certain right to privacy, which are outlined in the HIPAA form provided. This information will be used for:

1. Plan, conduct and direct your treatment and follow up among multiple health care providers involved in your treatment.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessment and physician certification.

A. **Family and Friends:** It is the office policy of MIND not to release confidential medical information regarding your treatment to family members or friends, except for:

I. Parent/legal guardian
II. Other persons authorized by the patient
III. As we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment.
IV. In emergency situations or
V. As otherwise permitted by the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, caregivers/babysitters, please indicate that below, so that we may best serve you. By signing below, you authorize the following persons to receive information as requested, regarding your care and treatment. Updated to this form must be made in person.

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

B. **ALTERNATIVE COMMUNICATION:** I wish to be contact in the following manner.
(check all that apply)

Home Phone: _____
☐Okay to leave message with details
☐Leave a call back number only
Work Phone: _____
☐Okay to leave message with details
☐Leave a call back number only

Cell Phone: _____
☐Okay to leave message with details
☐Leave a call back number only
Written Communication
Email: _____

You have a right to review a NOTICE OF PRIVACY PRACTICES prior to signing this consent. This organization has the right to change its notice of privacy practices from time to time and that you may contact this organization at any time to obtain a copy of the notice of privacy practices. You may revoke this consent at any time.

X_____	_____	_____
Patient or Representative Signature	Relationship to Patient	Date

Revised 11/2019 TJS/MBR