



Houston Methodist Sugar Land Neurology Associates

16605 SW Freeway, Suite 600
Sugar Land, TX 77479
(281) 274-7595 Office (281) 494-6410 Fax

Carisa Liew, D.O.

Rony Ninan, M.D

Jinal Shah, M.D.

Larry Tran, M.D.

Toby Yaltho, M.D.

Board Certified in Adult Neurology

We appreciate the trust you’ve placed in us to provide your specialty care. The following information clarifies our respective responsibilities in providing and receiving information. Our patient care procedures have been developed over time to maximize your visit experience and outcome.

New Patients: New patients are usually referred to us by their primary care physician or other specialist. If you have received diagnostic testing of any kind (x-ray, MRI, CT, laboratory) related to this visit, please bring the test results with you or have them forwarded to us prior to your visit.

If you are insured with an HMO, your primary care physician will provide a written referral that includes their diagnosis for referral. Without a referral, we will not be able to bill your insurance and you may be asked to pay in full at the time of visit.

Please bring the following:

- Written referral – HMO insurance only
- Results of tests ordered by referring MD
- New patient forms
- Insurance card
- Photo ID

Appointments: We attempt to contact patients 24-48 hours prior to their appointment. Our schedule is usually booked several weeks in advance, so we ask for at least one business day notice for cancellation. **Failure to notify our office of cancellation at least one full business day prior to your scheduled appointment or not appearing for your scheduled appointment may result in a No- Show fee.**

Test Results: Test results are given during a follow-up visit only. You will be asked to schedule an appointment to discuss results of any tests ordered by our physicians to avoid misunderstandings and improve the patient care outcome. Please do not contact the office for a copy, fax, or verbal disclosure prior to your follow-up appointment. NOTE: You will be contacted should any result require action prior to your scheduled follow-up appointment.

Forms: We will not complete disability, FMLA, or functional capacity evaluation forms.

Refills: Medications prescribed by our physicians may be refilled if you have been seen within the last year. Refills will not be approved after office hours or on weekends. We do not call mail order pharmacies as they require a written prescription.

Signature of Acknowledging Party:	Date:
-----------------------------------	-------

PAST MEDICAL HISTORY
COMPLETE IN DETAIL

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

SURGICAL HISTORY (CHECK BOXES THAT APPLY TO YOUR PAST SURGICAL HISTORY)

Appendectomy Cataract Gyn Surgery Gallbladder Tonsillectomy Hernia
Heart Surgery Pacemaker Other Surgeries: _____

MEDICAL HISTORY (CHECK BOXES THAT APPLY TO YOUR PAST MEDICAL HISTORY)

High Blood Pressure Diabetes Seizures Heart Disease Migraine Stroke
Thyroid Disease High Cholesterol
Cancer (Type of Cancer) _____
Other Medical or Neurological Problems _____

CURRENT MEDICATIONS & DOSAGE *please complete in detail*

SOCIAL HISTORY

Smoking? No Yes (If yes, please list how many packs per day and for how many years you have smoked)
_____Packs per day for _____year(s). Date Quit Smoking _____

Alcohol? No Yes (If yes, please indicate the number of drinks per day, number of years, and type(s) of alcohol used)
_____drink(s) per day for _____year(s). Type(s) of drinks Beer Wine Mixed Drinks
Never used alcohol Hospitalized for alcohol use

EMPLOYMENT Job Title _____

Exposures: Noise Chemicals Toxins Fumes Gases

EDUCATION Highest level Achieved _____

FAMILY HISTORY (please list those people in your family with the following illnesses):

High Blood Pressure: _____ Heart Disease: _____
Diabetes: _____ Cancer: _____
Stroke: _____ Migraine: _____
Seizures: _____ Parkinson's: _____
Alzheimer's: _____ Other Neurological Problems: _____

Patient Symptoms

Constitutional Symptoms

If Yes, please explain

Good general health lately:	No	Yes	_____
Recent weight change:	No	Yes	_____
Fever:	No	Yes	_____
Fatigue:	No	Yes	_____
Headaches:	No	Yes	_____

Eyes

Eye disease or injury:	No	Yes	_____
Wear glasses / contact lens:	No	Yes	_____
Blurred or double vision:	No	Yes	_____
Glaucoma:	No	Yes	_____

ENT

Hearing loss or ringing:	No	Yes	_____
Nose bleeds:	No	Yes	_____
Swollen glands in neck:	No	Yes	_____

Cardiovascular

Heart trouble:	No	Yes	_____
Chest pain or angina pectoris:	No	Yes	_____
Palpitation:	No	Yes	_____
Shortness of breath with walking or laying flat:	No	Yes	_____
Swelling of feet, ankles or hands:	No	Yes	_____

Respiratory

Chronic or frequent coughs:	No	Yes	_____
Spitting up blood:	No	Yes	_____
Shortness of breath:	No	Yes	_____
Asthma or wheezing:	No	Yes	_____

Gastrointestinal

Change in bowel movements:	No	Yes	_____
Nausea or vomiting:	No	Yes	_____
Rectal bleeding or blood in stool:	No	Yes	_____
Abdominal pain or heartburn:	No	Yes	_____
Peptic ulcer (stomach or duodenal):	No	Yes	_____

Genitourinary

Frequent urination:	No	Yes	_____
Burning or painful urination:	No	Yes	_____
Blood in urine:	No	Yes	_____
Incontinence or dribbling:	No	Yes	_____
Kidney stones:	No	Yes	_____

Patient Name: _____

Date: _____

Patient Symptoms (cont.)

Musculoskeletal

If Yes, please explain

Joint pain:	No	Yes	_____
Joint stiffness or swelling:	No	Yes	_____
Weakness of muscles or joints:	No	Yes	_____
Muscle pain or cramps:	No	Yes	_____
Back pain:	No	Yes	_____
Cold extremities:	No	Yes	_____
Difficulty in walking:	No	Yes	_____

Integumentary (skin)

Rash or itching:	No	Yes	_____
Change in skin color:	No	Yes	_____
Varicose veins:	No	Yes	_____

Neurological

Frequent or recurring headaches:	No	Yes	_____
Lightheaded or dizzy:	No	Yes	_____
Convulsions or seizures:	No	Yes	_____
Numbness or tingling sensations:	No	Yes	_____

Psychiatric

Memory loss or confusion:	No	Yes	_____
Nervousness:	No	Yes	_____
Depression:	No	Yes	_____
Insomnia:	No	Yes	_____

Endocrine

Excessive thirst or urination:	No	Yes	_____
Heat or cold intolerance:	No	Yes	_____

Hematologic / Lymphatic

Bleeding or bruising tendency:	No	Yes	_____
Anemia:	No	Yes	_____
Phlebitis:	No	Yes	_____
Past transfusion:	No	Yes	_____

Allergies: History or Reaction to Medicines or Other Agents

Penicillin: No Yes

Other antibiotics: No Yes (list): _____

Morphine, Demerol, or other narcotics: No Yes

Novocain or other anesthetics: No Yes

Aspirin or other pain remedies: No Yes

Iodine, methiolate or other antiseptic: No Yes

Tetanus antitoxin or other serums: No Yes

Other drugs / medications: _____

Patient Name: _____ Date: _____



Houston Methodist Sugar Land Neurology Associates

16605 SW Freeway, Suite 600
Sugar Land, TX 77479
(281) 274-7595 Office (281) 494-6410 Fax

**PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION
TO FRIENDS AND FAMILY**

We value your privacy and ask that you help us identify the persons whom you would like us to discuss your health care. (Including, but not limited to: test results, recent visits, medication requests, appointment information, and billing/insurance information).

I GIVE PERMISSION for TMH Physician Organization dba Methodist Sugar Land Neurology Associates to disclose relevant health information to my family members and to the individual(s) I have listed below:

1st Name: _____ Relationship _____

Phone: _____

2nd Name: _____ Relationship _____

Phone: _____

3rd Name: _____ Relationship _____

Phone: _____

4th Name: _____ Relationship _____

Phone: _____

Patient Name

Signature of Patient or Patient's Qualified Personal Representative

Date

Printed Name of Qualified Personal Representative

Legal Authority to Act on Behalf of the Patient

*This does not authorize copies of PHI to be mailed or faxed to the persons listed. To obtain copies of PHI a valid HIPAA release is required