MedStar Georgetown University Hospital

Department of Neurosurgery
Brain and Spine Surgery
Alexandros Powers, MD
Amjad Anaizi, MD
Nathan Nair, MD

Clinic Flow Sheet

Patient Name: _____ DOB: _____ Date: _____

Today's appointment is a: New Patient Return Visit Post Op: Surgery Date: _____

Circle any recent diagnostic imaging or conservative treatment(s): Where Completed? _____

MRI CT Scan X-Ray Injections Physical Therapy Steroids

What is your Height: _____ Weight: _____

Where are you having problems? _____

How long ago did this problem start? _____ Days _____ Weeks _____ Months _____ Years

How frequently do you experience this problem? constantly daily weekly monthly yearly

How would you describe this problem? Dull/achy sharp numb tingling burning other _____

What makes your problem worse? lifting bending sitting walking standing other_____

Does your problem radiate? Yes / No If yes: Right / Left / Bilateral

New allergies: Yes / No If yes: _____

Changes to your medications: Yes / No If yes: _____

Smoking History: Yes / No If yes: Current / Former

Please circle the number below that best describes your current level of pain:

0	No Pain	4	Moderate	8	Intense
1	Minimal	5	Distracting	9	Severe
2	Mild	6	Distressing	10	Bed Ridden
3	Uncomfortable	7	Unmanageable		

Authorization to Discuss Protected Health Information (PHI)

Please list anyone below who you authorize our practice, MedStar Georgetown University Hospital Department of Neurosurgery, to communicate with regarding your care with our practice.

Name of Individual(s) _____

MedStar Georgetown University Hospital

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Patient Name: _____ DOB: _____ Date: _____

Allergies

Medication	Symptom(s)

Current Medications

Medication	Dosage	Frequency

Past Surgical History

Date	Surgery	Hospital Name	Complications

Major Medical History

Date	Diagnosis

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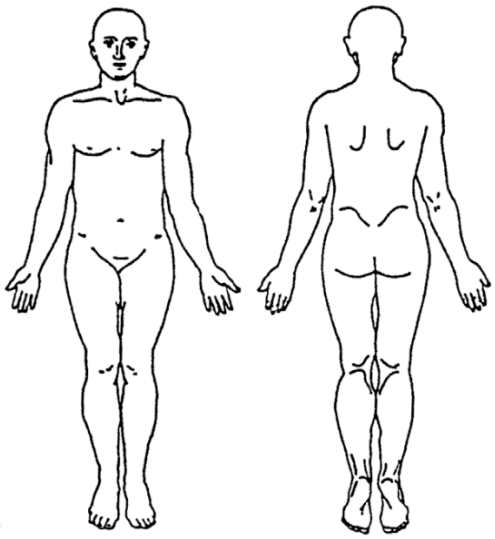
Review of Systems	Please circle all **CURRENT** problems							
Constitutional	Weight Loss	Fevers	Chills	Poor Appetite	Fatigue	Weight Gain	Insomnia	Night Sweats
Eyes	Blurry Vision	Eye Pain	Eye Discharge	Eye Redness	Decrease in Vision	Dry Eyes	Double Vision	
ENT	Sore Throat	Hoarseness	Ear Pain	Hearing Loss	Ear Discharge	Nose Bleeds	Tinnitus	Sinus Problems
Cardiovascular	Chest Pain	Palpitations	Rapid heart rate	Heart murmur	Poor circulation	Swelling in the legs or feet		
Respiratory	Shortness of breath	Chronic cough	Coughing up blood	History of Tuberculosis	Excess sputum			
Gastrointestinal	Nausea	Vomiting	Diarrhea	Constipation	Blood in Stool	Frequent Heart Burn	Trouble Swallowing	
Genitourinary	Increase urinary frequency	Blood in urine	incontinence	Painful urination	Urinary retention	Frequent UTI's		
Skin	Rash	Hives	Hair loss	Skin sores or ulcers	Itching	Skin thickening	Nail changes	Mole changes
Musculoskeletal	Joint pain	Muscle aches	Frequent leg cramps	Muscle weakness	Bone pain	Joint swelling	Back pain	
Psychiatric	Anxiety	Depression	Alcohol or drug dependence	Suicidal thoughts	panic attacks	Use of anti-depressants		
Endocrine	Goiter	Heat intolerance	Cold Intolerance	Increased thirst	Change in skin pigment	Excess sweating		
Neurological	Seizures	Tremors	Migraines	Numbness	Dizziness/Vertigo	Loss of balance	Slurred speech	Stroke
Hem/Lymphatic	Low blood count	Easy bruising	Swollen lymph nodes	Transfusions	Prolonged bleeding	Blood clots		
Allergic/Immune	Allergic reactions	Hay fever	Frequent infections	Hepatitis	HIV positive	Positive Tuberculin test		

Please circle areas where you are having pain.



Knowledge and Compassion
Focused on You

MedStar Georgetown University Hospital

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Nathan Nair, MD

Patient Name: _____ DOB: _____ Date: _____

Social History

Do you drink alcohol? Yes No Do you use recreational drugs? Yes No

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Family History

Significant Health Problems

Father _____

Mother _____

Siblings _____

Children _____

Has anyone in your family had any problems with anesthesia? Yes No

Has anyone in your family had unusual bleeding with surgery? Yes No

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Name and address of Preferred Pharmacy_____

Who is your primary care doctor?_____

Who referred you to our practice? Self Friend Doctor Name_____

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information (PHI)

I authorize the custodian of records of: _____ to disclose/release all medical records to providers or associates of MedStar Georgetown University Hospital Department of Neurosurgery for the purpose of providing medical treatment.

Please send records to: Dr. Alexandros Powers
18109 Prince Philip Dr. Suite 300
Olney, MD 20832

301-570-8554 (P)
844-304-5292 (F)

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature of patient or representative_____ Date _____

Printed name of patient or representative _____