Vincent Macaluso MD

Intake Form

DEMOGRAPHICS

Date_____

First Name_____ **M.I.** _____ **Last Name**_____

Date of Birth: _____ **Social Security Number:** _____

Address _____ **Apt.** _____

City and State _____ **Zip Code** _____

Email Address: _____ **Marital Status**: _____

Phone: HOME _____ CELL_____

WORK _____ **Which is your primary number?** H___ W ___ C___

Primary Insurance: _____ **Secondary:** _____

ID & Group # _____ ID & Group #_____

Policy Holder Name _____ Policy Holder Name _____

Policy Holder SSN _____ Policy Holder SSN _____

Policy Holder DOB _____ Policy Holder DOB _____

Primary Care Doctor's Name: _____

Address _____ Phone Number _____

_____ Fax Number _____

Referring Doctor's Name:_____

Address _____ Phone Number _____

_____ Fax Number _____

Pharmacy's Name: _____

Phone Number _____ Fax Number _____

HISTORY OF PRESENT ILLNESS

1. Which hand do you usually write with? Right___ Left___
2. What is the chief problem you're coming in for?_____
3. When did you start having symptoms related to this problem (Month/Year)?_____
4. Did anything make the symptoms better?_____
5. Did anything make the symptoms worse?_____
6. If the symptoms occur in a certain part of your body, where are they?_____
7. If the symptoms spread from one place to another, where do they start and then go to?____

_____

8. If you have a painful component to your problem:

9. How bad is it on a scale of 0-10 (0 = no pain, 10 = the worst imaginable pain)?_____

10. Is the nature of the pain:

Burning___ Shock-like___ Stabbing___ Pressure___ Other_____

11. If your problem is intermittent, how often does it occur:

Constantly___ Everyday___ Weekly___ Monthly___ Other_____

12. When the problem comes on, how long does it last for?_____

13. If you have had your problem previously, has it worsened recently? YES___ NO___

REVIEW OF SYSTEMS

Please check only those that apply. Otherwise **LEAVE THE ITEM BLANK**.

General symptoms

___ Weight gain – how much? ____
___ Weight loss – how much? ____
___ Eating a lot
___ Drinking a lot
___ Bleeding problems
___ Cold intolerance
___ Heat intolerance
___ Fatigue
___ Fever
___ Hot flashes
___ Night sweats
___ Swollen glands
___ Recent infection
___ TB exposure
___ Transfusions
___ Trauma
___ Weakness

Neurological

___ Memory
___ Concentration
___ Processing speed
___ Initiative
___ Clumsiness
___ Double vision
___ Extreme fatigue
___ Falls
___ Flipping word order
___ Word production
___ Confusion
___ Disorientation
___ Dizziness
___ Seizures
___ Slurred speech
___ Syncope
___ Tremor

Psychiatric

___ Irritability
___ Anxiety
___ Depression
___ Rapid mood swings
___ Hallucinations
___ Insomnia
___ Restlessness
___ Suicidal Ideation
___ Schizophrenia
___ Bipolar disease

Musculoskeletal

___ Painful joints/Arthralgia
___ Joint Stiffness/Swelling /Arthritis
___ Upper back pain
___ Mid back pain
___ Lower back pain
___ Arm swelling
___ Leg swelling
___ Arm pain
___ Leg pain

___ Heel pain
___ Hip pain
___ Trouble with walking
___ Muscle ache
___ Muscle pain
___ Muscle cramps
___ Muscle twitching

Eyes

___ Blurred vision
___ Pain behind eye
___ Partial loss of vision in one eye
___ Partial loss of vision in both eyes
___ Blindness in one eye
___ Blindness in both eyes
___ Wear glasses
___ Wear contacts
___ Tearing
___ Exudates
___ Red eyes
___ Glaucoma
___ Cataracts

Ears, Mouth, Nose and Throat

___ Loud sounds bother you
___ Ear pain
___ Ringing in ears
___ Ear drainage
___ Dental problems
___ Tooth pain
___ Tongue pain
___ Drooling
___ Bad breath
___ Dry mouth
___ Oral ulcerations
___ Pain with eating
___ Trouble with eating
___ Runny nose
___ Post nasal drainage
___ Sinus problems
___ Excessive sneezing
___ Pain with swallowing
___ Trouble with swallowing
___ Facial pain
___ Sore throat

Neck

___ Hoarseness
___ Limited motion
___ Pain
___ Swelling

Cardiovascular

___ Chest pain
___ Murmur
___ Palpitations
___ High blood pressure
___ Heart trouble
___ Arrhythmia
___ Palpitations
___ Swelling of feet/ankles
___ Phlebitis

Respiratory

___ Cough
___ Blood in sputum
___ Shortness of breath when sleeping
___ Shortness of breath at rest
___ Bronchitis
___ Chronic cough
___ Emphysema
___ Wheezing

Genitourinary

___ Breast discharge
___ Breast mass
___ Breast pain
___ Urinary frequency
___ Urinary hesitancy
___ Urinary incontinence
___ Sexual interest
___ Sexual arousal
___ Orgasm
___ Sexual satisfaction
___ Dark urine
___ Genital ulcers
___ Groin pain
___ Blood in urine
___ Hemorrhoids
___ Getting up at nighttime to urinate
___ Pelvic pain
___ Rectal pain
___ Suprapubic pain
___ Urethral discharge
___ Slow urinary flow

Men

___ Impotence
___ Testicular mass
___ Testicular pain

Abdominal & Gastrointestinal

___ Abdominal pain

___ Belching
___ Fecal urgency
___ Constipation
___ Fecal incontinence
___ Diarrhea
___ Flank pain
___ Flatulence
___ Hernia
___ Bloody stools
___ Nausea
___ Vomiting

___ Bruising
___ Cysts
___ Sweatiness
___ Hair problems
___ Jaundice
___ Mole changes
___ Itchiness
___ Rash
___ Skin lesions
___ Varicose veins
___ Hands become blue when cold

Skin

___ Tick bite

PAST MEDICAL HISTORY Please list any medical problems that you have (High Blood Pressure, Diabetes, etc.) If you have or ever had a condition where you needed to be treated with chemotherapy (for arthritis, cancer, etc.) please list the chemotherapy that was used.

_____

_____

_____

_____

SURGICAL HISTORY Please list any surgeries & dates that you had them.

MONTH/YEAR **SURGERY –** If applicable, please mention which side of the body was operated on.

_____ _____

_____ _____

_____ _____

_____ _____

YOU

1. Overall, how do you currently feel?

   Excellent___ Pretty good___ Okay___ Blah___ Stick a fork in me 'cuz I think I'm done ___

2. Do you require sedation for MRI's because of claustrophobia? YES___ NO___

3. How tall are you? ____feet _____inches

4. How much do you weigh?_____lbs.

5. What are some things you like to do? _____

6. What is the biggest problem that MS presents you with? _____

_____

SOCIAL HISTORY

1. Are you currently working? YES___ NO___

If **NO**, are you retired? YES___ NO___

If **NO,** are you on disability? YES___ NO___

2. What is or was your occupation? _____

3. Do you drink alcohol? YES___ NO___

If **YES**, how much & how often? _____

4. Do you smoke? YES___ NO___

If **NO**, have you ever? YES___ NO___

If **YES**, **how many packs per day** did you or do you smoke?

___ ¼ pack ___ ½ pack ___ 1 pack ___ 2 packs ___ 3 packs ___ 4 packs ___ 5 or more

If **YES**, what year did you start smoking? _____

If you quit smoking, when did you quit? _____

5. Do you get your heart rate up for 30min, at least 5 times a week? (In the 140-160 beats per minute range where you sweat & breath heavily.) YES___ NO___

6. Do you eat at least 5 fruits and/or vegetables a day? YES___ NO___

7. Do you drink 1-2 liters of water per day? YES___ NO___

8. Are you currently in physical therapy? YES___ NO___

9. Are you a student? YES___ NO___

If **YES**, where and what are you studying? _____

10. Check off all that you have **completed**: Elementary____ HS____ GED____ Technical/Vocational____

Associate____ Bachelor's____ Master's____ Doctoral____

11. What was your GPA? If you don't know the number, were you an A, B, C or D student? If you were in between, you can write it like "A to B", "C to D", etc. _____

12. How much do you drink of the following?

TYPE	**HOW MUCH**	**HOW OFTEN**
Coffee	_____	_____
Caffeinated Tea	_____	_____
Soda	_____	_____
Water	_____	_____

FAMILY HISTORY If a relative has no medical problem, write "gh" for good health.

Relative	**Alive**	**Deceased**	**Medical Problems / Cause of Death**
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)	#____	#____	_____
Sister(s)	#____	#____	_____
Daughter(s)	#____	#____	_____
Son(s)	#____	#____	_____

Please list any other relatives with chronic disease. (MS, Lupus, Sarcoidosis, etc.)

Please check off if you are _____adopted or _____a foster child.

ALLERGIES – Please list any allergies that you have.

FOOD:	**MEDICATION:**	**ENVIRONMENTAL:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS – Please list ALL the meds you are on including vitamins & over the counter meds.

NAME	**DOSAGE (MG)**	**How many times a day/week/month do you take it?**
_____	_____	_____
_____	_____	_____

AUTHORIZATION AND RELEASE:
I AUTHORIZE THE RELEASE OF ANY INFORMATION, INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD OF SUCH CARE TO THIRD PARTY PAYERS, AND/OR OTHER HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DOCTOR ANY INSURANCE OTHERWISE PAYABLE TO ME.

FINANCIAL ARRANGEMENTS:
FOR YOUR CONVENIENCE, WE ACCEPT CASH AND PERSONAL CHECK TOWARD PAYMENT. PAYMENT IN FULL AT EACH APPOINTMENT IS REQUIRED, UNLESS OTHER ARRANGEMENTS ARE MADE. I UNDERSTAND THAT IF AN INSURANCE CLAIM IS DENIED, FOR ANY AND ALL SERVICES RENDERED TO ME (BASED ON ELIGIBILITY), BY MY INSURANCE CARRIER, I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES INCURRED.

PRINT NAME: _____

SIGNATURE: _____

DATE : _____

Note to All Patients

Because of the high incidence of controlled substance abuse that is currently going on, before any Class II, III, IV or V medications are dispensed, Dr. Macaluso has to run a Confidential Patient Drug Utilization Profile Report through the New York State Department of Health. It is necessary that you list ALL of the medications that you take and list all of the Doctors, Nurses, Physician Assistants or anyone else who dispenses any controlled substance to you. A controlled substance is any medication that requires a prescription in order to be filled and cannot have refills on it. Some examples include, but are not limited to:

Narcotics

codeine	buprenorphine (Buprenex)	butorphanol (Stadol)
fentanyl (Duragesic)	hydrocodone	hydromorphone (Dilaudid)
levorphanol	meperidine (Demerol)	methadone
morphine	nalbuphine (Nubain)	oxycodone (OxyContin, OxyFast, Roxicodone)
oxymorphone	Pentazocine (Talwin)	propoxyphene

Attention Deficit Disorder Medications

dextroamphetamine /amphetamine (Adderall)	dexmethylphenidate hydrochloride (Focalin)	dextroamphetamine (Dexedrine, Dextrostat)
Lisdexamfetamine (Vyvanse)	methylphenidate hydrochloride (Concerta, Daytrana, Metadate, Methylin, Ritalin)	pemoline (Cylert)

Patient Name: _____

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Controlled Substances Agreement

We are committed to doing all we can to treat your neurological condition. In some cases, controlled substances are used as a therapeutic option in the management of neurological diseases, including, but not limited to, tremors, anxiety, ADHD and chronic pain. These controlled substances are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the practice by establishing guidelines, within the laws, for proper controlled substance use. In this agreement, the words "we" and "our" refer to Vincent F. Macaluso MD PC (which includes Dr. Vincent F. Macaluso and his appointees) and the words "I," "you," "me," or "my" refer to you, the patient.

1. All controlled substances must come from the physician whose signature appears below or, during his absence, by the covering physician, unless specific authorization is obtained for an exception. I understand that I must tell the physician whose signature appears below or, during his absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, including over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not seek prescriptions for controlled substances from any other physician, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician's knowledge. I also understand that it is unlawful to obtain or to attempt or obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician, or his staff, or knowingly withholding facts from a physician or his staff (including failure to inform the physician or his staff of all controlled substances that I have been prescribed).

2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

NAME: _____

PHONE: _____

3. You may not share, sell, or otherwise permit others, including spouse or family members, to have access to any controlled substances that you have been prescribed.

4. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility.

5. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or, during his absence by the covering physician, as set forth in Section 1

Patient Name: _____

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above. I will not use, purchase or otherwise obtain any illegal drugs, including marijuana, cocaine, heroin, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges.

6. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.

7. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

8. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.

9. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and that law enforcement officials may be contacted.

10. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this document has been given to me.

Patient's Full Name _____

Patient's Signature _____ Date _____

Physician's Signature _____ Date _____

Patient Name: _____

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