

DBS MEDICAL HISTORY

NO: Diathermy, Lithotripsy MRI or Ultrasound. Medical Consent Required.

PATIENT HISTORY

Name: _____ DOB: _____

Address: _____

Type of Residence: _____ Phone: _____

Marital Status: _____ Work Status: _____

Occupation (if employed): _____

Activity Level: Sedentary Moderately Active Very Active

Smoker: No Yes, Current Previous

Allergies (*check for YES*):

Aspirin Codeine Penicillin Local Anesthetics Acrylic Latex Metal

PATIENT PROGRAMMER

Device: _____ Manufacturer Contact: _____

Neurologist Contact: _____ Programmer Contact: _____

MEDICATIONS

NAME	DOSAGE	FREQUENCY	STRENGTH





PHYSICIANS

TYPE	DOCTOR NAME	HOSPITAL / CLINIC	ADDRESS CITY, STATE, ZIP	PHONE
Primary Care Physician				
Neurologist				
DBS Programmer				
DBS Surgeon				
Optometrist/Ophthalmologist				
Dentist				
Oral Surgeon				
OTHER				



MEDICAL INSURANCE

PRE-AUTHORIZATION

Claim #: _____

Entitled to: _____

Insurance Company: _____

Employee ID #: _____

Group Name: _____

Group Policy #: _____

Claim Inquiries: _____

EMERGENCY CONTACTS

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

IMMUNIZATIONS AND PREVENTATIVE SCREENINGS

TYPE	DATE
Flu	
Pneumonia	
Tetanus	
Hepatitis B	
Shingles	
Gardasil	

TYPE	DATE
Colonoscopy	
EKG	
Echocardiogram	
Eye Exam	
Physical Exam	
Neurology Exam	



SURGICAL HISTORY

SURGICAL PROCEDURE	REASON FOR SURGERY	DATE	SURGEON NAME	HOSPITAL	CITY, STATE

EVERY VICTORY COUNTS