

## Nervous System Diseases Questionnaire

Last Name:		First Name:	
Date of Birth:		Age:	
Height :	Cm	Weight:	Kg
<b>Treating Physician's Demographics:</b>			
Name, address and telephone number of present attending Physician:			
Frequency of visits to physician:		Date of last visit: / /	
Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, how many cigarettes per day? If No, did you ever smoke? Yes <input type="checkbox"/> No <input type="checkbox"/>	For How many years? When did you stop?	
<b>Do you Suffer from Depression?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> (if the answer is No, please proceed to the next section)			
Please State the Diagnosis:			
List the number of Episodes: _____		Where you hospitalized for that disease? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are you on any medication? Yes <input type="checkbox"/> No <input type="checkbox"/> (if Yes, please list name, dose and route of administration below)			
Have you ever received Electroshock Treatment? Yes <input type="checkbox"/> No <input type="checkbox"/> last date received: / /			
Do you have a history of any of the following condition?, if Yes, please provide details regarding the condition stated:			
*Substance Abuse (Alcohol or Drugs)? Yes <input type="checkbox"/> No <input type="checkbox"/>		Personality Disorder Yes <input type="checkbox"/> No <input type="checkbox"/>	
Psychotic Disorder Yes <input type="checkbox"/> No <input type="checkbox"/>		Suicidal thought/attempt Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Do you Suffer from Seizure Disorder (Epilepsy)?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> (if the answer is No, please proceed to the next section)			
Date of first seizure: __/__/__		Type of seizure: _____	
		How frequent are the seizures? _____	
Date of Last seizure: __/__/__		During Seizures, do you loose consciousness? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you have "warnings" before seizures? Yes <input type="checkbox"/> No <input type="checkbox"/>		Do you take medications Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Other Nervous System Disorders</b> Yes <input type="checkbox"/> No <input type="checkbox"/>			
• Amnesia: Yes <input type="checkbox"/> No <input type="checkbox"/>		• Tremor: Yes <input type="checkbox"/> No <input type="checkbox"/>	
• Stroke (CVA): Yes <input type="checkbox"/> No <input type="checkbox"/>		• Parkinson's Disease: Yes <input type="checkbox"/> No <input type="checkbox"/>	
• Transient Ischemic Attack (TIA): Yes <input type="checkbox"/> No <input type="checkbox"/>		• Dementia: Yes <input type="checkbox"/> No <input type="checkbox"/>	
• Organic Brain Syndrome: Yes <input type="checkbox"/> No <input type="checkbox"/>		• Alzheimer's Disease: Yes <input type="checkbox"/> No <input type="checkbox"/>	
• Other Neurologic Disease: Yes <input type="checkbox"/> No <input type="checkbox"/> Please Explain: _____			
Please Provide the starting date: / / and number of occurrences of the disease: _____			
Please specify the special test(s) or study(ies) performed along with their dates and results:			
*CT Scan: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: __/__/__ Result: _____		*Echocardiogram: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: __/__/__ Result: _____	
*MRI: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: __/__/__ +Result: _____		*Stress Test: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: __/__/__ Result: _____	
*Carotid Ultrasound: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: __/__/__ Result: _____		*Cerebral Evoked Potential: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: __/__/__ Result: _____	
*EEG: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: __/__/__ Result: _____		*Other (Please specify): _____ Date: __/__/__ Result: _____	
Are you fully recovered? Yes <input type="checkbox"/> No <input type="checkbox"/> Specify: _____			
Do you require assistance for your daily living tasks? Yes <input type="checkbox"/> No <input type="checkbox"/> Specify: _____			

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<b>Medications:</b>			
Are you on any medication? Yes <input type="checkbox"/> No <input type="checkbox"/> (if Yes, please list name, dose and route of administration):			
• Name:	Dosage:	• Name:	Dosage:
• Name:	Dosage:	• Name:	Dosage:
• Name:	Dosage:	• Name:	Dosage:
Have you ever had (give dates, names, addresses and telephone numbers of Attending Physicians):			
Stroke?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Eye trouble?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Rhythm Problem?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Liver Problem?	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Cholesterol level?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney Disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any Other Complication?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Edema?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Do other members of your family have a neurologic Disease? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, who and what is the disease?			
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-			
-			
-			

Attending Ph. \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby, give full and irrevocable authorization to the Insurance Company, to the Administrator and to MedNet Delegates' (Physician and Nurses), to inquire about my actual state of health and that of my dependents from any Medical Center or Hospital or Doctor, and I waive my right of medical confidentiality to the benefit of the Insurance Company, the Administrator and MedNet Delegates'. Failure to disclose material information, whether by omission or false declaration, which the Insurance Company should have known, the latter will have the right to cancel my or my dependents' rights in coverage starting from the effective date of the policy without having any financial obligation.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_