Nervous System Diseases Questionnaire

Last Name:	First Name:
Date of Birth:	Age:
Height : Cm	Weight: Kg

Treating Physician's Demographics:

Name, address and telephone number of present attending Physician:

Frequency of visits to physician:	Date of last visit: / /

Do you smoke? Yes ☐ No ☐	If yes, how many cigarettes per day?	For How many years?
	If No, did you ever smoke? Yes ☐ No ☐	When did you stop?

Do you Suffer from Depression? Yes ☐ No ☐ (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 ☐ No ☐

Are you on any medication? Yes ☐ No ☐ (if Yes, please list name, dose and route of administration below)

Have you ever received Electroshock Treatment? Yes ☐ No ☐ 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 ☐ No ☐	Personality Disorder Yes ☐ No ☐
Psychotic Disorder Yes ☐ No ☐	Suicidal thought/attempt Yes ☐ No ☐

Do you Suffer from Seizure Disorder (Epilepsy)? Yes ☐ No ☐ (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 ☐ No ☐

Do you have "warnings" before seizures? Yes ☐ No ☐	Do you take medications Yes ☐ No ☐

Other Nervous System Disorders Yes ☐ No ☐

• Amnesia: Yes ☐ No ☐	• Tremor: Yes ☐ No ☐
• Stroke (CVA): Yes ☐ No ☐	• Parkinson's Disease: Yes ☐ No ☐
• Transient Ischemic Attack (TIA): Yes ☐ No ☐	• Dementia: Yes ☐ No ☐
• Organic Brain Syndrome: Yes ☐ No ☐	• Alzheimer's Disease: Yes ☐ No ☐

• Other Neurologic Disease: Yes ☐ No ☐ 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 ☐ No ☐ Date:___/___/____ Result:	*Echocardiogram: Yes ☐ No ☐ Date: ___/___/____ Result:
*MRI: Yes ☐ No ☐ Date: ___/___/____ +Result:	*Stress Test: Yes ☐ No ☐ Date: ___/___/____ Result:
*Carotid Ultrasound: Yes ☐ No ☐ Date: ___/___/____ Result:	*Cerebral Evoked Potential: Yes ☐ No ☐ Date: ___/___/____ Result:
*EEG: Yes ☐ No ☐ Date: ___/___/____ Result:	*Other (Please specify): _____ Date: ___/___/____ Result:

Are you fully recovered? Yes ☐ No ☐ Specify: _____

Do you require assistance for your daily living tasks? Yes ☐ No ☐ Specify: _____

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Medications:			
Are you on any medication? Yes ☐ No ☐ (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 ☐ No ☐	Eye trouble?	Yes ☐ No ☐
Heart Rhythm Problem?	Yes ☐ No ☐	Diabetes?	Yes ☐ No ☐
Liver Problem?	Yes ☐ No ☐	High Cholesterol level?	Yes ☐ No ☐
Kidney Disease?	Yes ☐ No ☐	Any Other Complication?	Yes ☐ No ☐
Edema?	Yes ☐ No ☐		

Do other members of your family have a neurologic Disease? Yes ☐ No ☐

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 _____/_____/_____