Neurology Clinic

Neurology Clinic | Stanford Neuroscience Health Center, SNHC

213 Quarry Rd, Palo Alto, CA 94304 | 650-723-6469

Stanford HEALTH CARE

STANFORD MEDICINE

Below you will find helpful information about our clinic. Please take a few moments to review the contents.

Test Results

If you are having your labs done outside of the Stanford Network, Please ask your lab to **fax the results to 650-725-0390**.

If you are being seen at the Neuromuscular Program:

If you are scheduled to attend the multidisciplinary clinic on Tuesday or Thursday, you may see a team of neuromuscular specialists, including physical therapy, occupational therapy, social work, respiratory therapy and others as needed. This team approach to care means your appointments may be two hours or more. If your appointment is scheduled during the multidisciplinary clinic, please park in the parking structure and bring a snack and reading material.

Appointments/Cancellation

Stanford Neuroscience Clinic is part of a teaching institution. You may see more than one physician, nurse, or trainee.

While you are waiting in the examination room the team will be reviewing records and x-rays that have been provided as well as discussing diagnosis and treatment recommendations for your condition.

Please fill out the enclosed Health History form. Having this information completed prior to arrival will avoid delay and assist your physician in understanding your health needs. It is important to communicate the prescriptions and medications you are taking.

If you have MRI, CT, X-ray or relevant medical records related to the reason for your visit that was done ***outside*** *of Stanford Healthcare,* upload your images or CD's electronically by using the secured link emailed to you ***. You must hand carry the actual films or CD and records to your appointment****.*

We ask that you please check-in at our front desk 30 minutes prior to your appointment time to complete the registration process. We make every effort to see you at your scheduled time and ask that you please arrive on time for your visit. For late arrivals, we cannot guarantee that you will be seen; however, the clinic will try their best to accommodate you if there is an appointment slot available or you will be offered to reschedule at a later date. If you need to reschedule your appointment, please call the clinic **48 hours** in advance at **650-723-6469**. You will also be contacted via an automated system to confirm your appointment, please listen to the entire message as its contents has valuable information including the ability to respond yes or no to confirm or cancel your appointment.

Allow plenty of time to find your way to the area, park, and check-in and complete any additional paperwork. A map is included for your convenience. Paid parking is available.

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<u>Driving Directions:</u>

<u>From Bayshore US Highway 101 North or South</u>

- *Take the Embarcadero Road/West exit.*
- *Follow Embarcadero Road for about two miles.*
- *Turn right on El Camino Real and left on Quarry Road.*
- *Turn left on Palo Road and right into the parking lot of SNHC.*
- *The SNHC is located at 213 Quarry Road.*

<u>From Highway 280 North or South</u>

- *Take the Sand Hill Road exit and head east.*
- *Turn right on Arboretum Road and left on Quarry Road.*
- *Turn right on Palo Road and right into the parking lot of SNHC.*
- *The SNHC is located at 213 Quarry Road.*

<u>El Camino Real North or South</u>

- *Turn on Quarry Road.*
- *Turn onto Palo Road and then into the parking lot of SNHC.*
- *The SNHC is located at 213 Quarry Road.*

Medical Record Number:
Name:
Date of Birth:
Encounter Date:
Provider:

STANFORDCLINICS

CENTER FOR NEUROMUSCULAR DISORDERS

Patient Questionnaire

PLEASE COMPLETE THIS FORM BEFORE YOUR APPOINTMENT

Patient Name: ________________________ Date of Birth: ___/___/___ Age: _____Sex: _____

Contact Name: _____________________________________ Phone Number: (_____)_____________

Pharmacy name and address: ____

Reason for today's visit: ____

Please complete the following so that our physicians can send a report to your physicians.

Referring MD Name: ____
Street Address: ____
City, State, Zip Code: ____
Phone (_____)______________________________ Fax (_____)___________________________

If you have a primary care physician other than your referring physician, please complete the following so that our physicians can send a report to your primary care physician.

Primary Care MD Name: ____
Street Address: ____
City, State, Zip Code: ____
Phone (_____)______________________________ Fax (_____)___________________________

Would you like the information from today's clinic appointment sent to any other physician?

MD Name: ____
Street Address: ____
City, State, Zip Code: ____
Phone (_____)______________________________ Fax (_____)___________________________

Medication Allergies	**Details (What was the reaction? When did it happen?)**

	Yes ✓	**No** ✓		**Yes** ✓	**No** ✓
Are you allergic to IV contrast or shellfish?			Have you ever had a CT scan?		
Do you have any metal in your body (e.g., stent, joint replacement, shrapnel, etc.)?			Have you ever had an MRI scan?		

Medications

	Name	Strength	Directions
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Please list any other medications or treatments you have had in the past for the current condition: (i.e., prednisone and other Rx drugs, over-the-counter drugs, physical therapy)	Have you had any of the following diagnostics or treatments?	Yes ✓	No ✓
	EMG/NCS		
	Nerve or Muscle Biopsy		
	Plasmapheresis		
	Immunoglobulin (IVIG)		

Medical History	Yes ✓	No ✓		Yes ✓	No ✓		Yes ✓	No ✓
Diabetes			Neuropathy			Multiple Sclerosis		
Thyroid disease			Muscle disease			Depression/Anxiety		
Alcohol Problem			Sleep Apnea			High Blood Pressure		
Drug abuse			Dementia			Atrial Fibrillation		
Cancer (Type_____________)			Parkinson's disease			Heart Attack		
Autoimmune disease			Seizure disorder			Other heart disease		
Kidney disease			Stroke/TIA			Blood clot		
Liver disease			Brain tumor			High Cholesterol		
Asthma, COPD, or emphysema			Migraine headache			Head Injury		

Surgical Histor y	Yes ✓	No ✓	Date		Yes ✓	No ✓	Date
Hip, knee, or other joint surgery				Cardiac catheterization / angioplasty			
Neck or back surgery				Carotid artery surgery			
Weight Loss surgery				Heart surgery			
Thymectomy				Cranial/brain surgery			

Please list any other medical history, surgeries, or hospitalization? When?

Social
People who live with you? ____
What is your occupation (or prior occupation, if retired)? ______________________
Hours worked per week (if retired, please state) ______________________
Describe the physical activity involved in your job: ______________________
Do you use any adaptive devices, such as cane, walker, grab bars? ______________
Do you exercise? If so, please describe ______________________________
Are there activities you can no longer do? Yes No If so, describe limitations, __________

Alcohol Use	Yes ✓	No ✓		
Have you ever suffered from alcohol dependence/abuse?			If you do drink now, then how many…	____ Can(s) of beer each week
Do you drink any alcohol now?				____ Shot(s) of liquor each week
				____ Glass(es) of wine each week

Tobacco Use		
Yes No	If yes, then…	Have you quit? Yes No If so, when? ________ Packs / day:______ Total years: _____

Family Health History:

Did any blood relative ever have?	Yes ✓	No ✓	Details (Whom? At what age was the first symptom?)
Neuropathy			
Muscle disease			
Diabetes			
Seizures			
Cataracts			
Sudden death			
Parkinson's disease			
Alzheimer's disease or other dementia			
Deafness			

	Living? (L) Deceased? (D)	Age (now or at death)	Medical Condition(s)
Mother			
Father			
Mother's Mom			
Mother's Dad			
Father's Mom			
Father's Dad			
Sister			
Sister			
Brother			
Brother			
Child			
Child			

History of Present Problem
How far back does the condition date?____
At what age did you start walking? ____________________________
Was your development different than your siblings or other children around you? ________________
If so, describe:____
Did you participate in sports as a child? ____
How has your condition changed since the initial symptoms? _________________________________
Have you experienced a loss of skills or function since the onset of your condition? ______________

Based on your identified needs, what therapists do you think you could benefit from seeing?	**Yes** ✓	**No** ✓
Speech Therapy (difficulty speaking or swallowing)		
Occupational Therapy (difficulty with fine motor skills and performing daily activities)		
Physical Therapy (difficulty with walking)		
Respiratory Therapy (difficulty breathing or clearing secretions)		

Review of Systems – Do you presently have any problems or symptoms in the following areas?	**Yes** ✓	**No** ✓	**Comments**	**Provider comments**
ALLERGIC/ IMMUNOLOGIC				
Low resistance to infection	___	___		
Environmental allergies	___	___		
CARDIOVASCULAR				
Chest pain or angina	___	___		
Irregular heart rhythm	___	___		
CONSTITUTIONAL				
Recent weight changes	___	___		
Good general health lately	___	___		
Recurrent fevers, chills, sweats	___	___		
Difficulty sleeping	___	___		
EAR, NOSE, and THROAT				
Change in hearing	___	___		
Ringing in the ears	___	___		
Voice changes	___	___		
EYES				
Changes in vision	___	___		
ENDOCRINE				
Heat or cold intolerance	___	___		
Excess thirst or urination	___	___		
GASTROINTESTINAL				
Change in appetite	___	___		
Nausea or vomiting	___	___		
Frequent diarrhea	___	___		
Constipation	___	___		
Black or bloody stools	___	___		
Abdominal pain	___	___		

Review of Systems – Do you presently have any problems or symptoms in the following areas?	Yes ✓	No ✓	Comments	Provider comments
GENITOURINARY				
Bloody urine or dark urine	___	___		
Difficult/frequent urination	___	___		
Lack of bladder control	___	___		
Sexually transmitted disease	___	___		
Change in sexual function	___	___		
HEMATOLOGIC/ LYMPHATIC				
Easy bruising or bleeding	___	___		
Enlarged lymph nodes	___	___		
INTEGUMENTARY				
Unusual or prolonged rashes Change in	___	___		
hair or nails	___	___		
MUSCULOSKELETAL				
Joint swelling Arthritis	___	___		
NEUROLOGIC				
Headaches	___	___		
Numbness/tingling sensation	___	___		
Weakness or paralysis	___	___		
Convulsions or seizures	___	___		
Change in memory/concentration	___	___		
Black-out/dizziness	___	___		
Memory loss or confusion	___	___		
Other neurological problems	___	___		
PAIN				
Joint stiffness or pain	___	___		
Muscle pain	___	___		
Neck/Back pain	___	___		
Other pain	___	___		
PSYCHIATRIC				
Nervousness	___	___		
Depression	___	___		
Other	___	___		
RESPIRATORY				
Breathing problems/shortness of breath	___	___		
Chronic cough	___	___		
Coughing up blood	___	___		

______________________________________ ______________________________________

Signature of Person Completing this Form Relationship if other than Patient

______________________________________ ______________________

Print Name **Date**

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Patient Parking Information for Hoover Pavilion Garage

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Visitor Parking

Hoover Pavilion Garage (Self-Parking)

- Serves: Hoover and Hoover 2
- Garage Hours: Open 24 hours a day
- Location: 217 Quarry Road
- Rates:
    - First Hour-Free
    - 1-2-$2
    - 2-3-$3
    - 3-4-$4
    - 4-5-$6
    - 5-6-$7
    - 6-7-$8
    - 7-8-$10
    - Daily Maximum-$12

DRIVING DIRECTIONS

From Highway 101 North/South

- *Exit Embarcadero Road West*
- *Follow Embarcadero Road for about 2 miles*
- *Cross El Camino Real (Embarcadero Rd. becomes Galvaz St.*
- *Turn right on Arboretum Rd. ○ Turn right on Quarry Rd.*
- *The Hoover Pavilion Garage will be on your right*

From Interstate 280 North/South

- *Exit Sand Hill Road East*
- *Follow Sand Hill Road for about 3 miles*
- *Turn right on Arboretum Rd.*
- *Turn left onto Quarry Rd.*
- *The Hoover Pavilion Garage will be on your right*