



## Neurology Clinic

Neurology Clinic | Stanford Neurosciences Health Center  
213 Quarry Rd | Palo Alto, CA 94304 | 650-723-6469

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 650-320-9443**.

### **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 reception area located on the 1<sup>st</sup> floor 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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### Driving Directions:

#### From Bayshore US Highway 101 North or South

- 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 Hoover Pavilion.
- The Hoover Pavilion is located at 213 Quarry Road.

#### From Highway 280 North or South

- 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 Hoover Pavilion.
- The Hoover Pavilion is located at 213 Quarry Road.

#### El Camino Real North or South

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

Medical Record Number:

Name:

Date of Birth:

Encounter Date:

Provider:

**STANFORD HOSPITAL and CLINICS  
STANFORD, CALIFORNIA 94305  
Neuroscience**

**Patient Questionnaire**

Full Name: \_\_\_\_\_ Appointment Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Pharmacy name and address: \_\_\_\_\_  
\_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

Did another physician refer you? Yes  No

If yes, please complete the following so that the Neuroscience Clinics physician can send a report to your referring physician.

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 that the Neuroscience Clinics 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 physician other than those listed above? Yes  No

MD Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this the result of a specific injury or accident?

Yes  No

Date of accident \_\_\_\_\_

Type of accident \_\_\_\_\_

Allergies	Reaction	Comments

Are you allergic to IV contrast or shell fish?      Yes       No

**Medications**

Name	Dose	How often taken?

**Medical History (circle 'yes' or 'no')**

Atrial Fibrillation	Yes No	Hepatitis C	Yes No	Parkinson's disease	Yes No
Aortic Stenosis	Yes No	Stomach ulcers	Yes No	Stroke	Yes No
Heart Disease	Yes No	Anemia	Yes No	Nerve/muscle disease	Yes No
Heart Failure	Yes No	Deep vein thrombosis	Yes No	Neurologic Disease	Yes No
High Cholesterol	Yes No	Leukemia	Yes No	Alcohol Problem	Yes No
High Blood Pressure	Yes No	Pulmonary embolism	Yes No	Depression	Yes No
Myocardial infarction	Yes No	Infection w/ MRSA (methacillin resistant staph)	Yes No	Asthma	Yes No
Blood clotting disorder	Yes No	Infection with VRE	Yes No	Emphysema (COPD)	Yes No
Heart Murmur	Yes No	Dementia	Yes No	Obstructive sleep apnea	Yes No
Artificial heart valve	Yes No	Seizure Disorder	Yes No	Tuberculosis	Yes No
Blood vessel blockage (arm or leg)	Yes No	Brain tumor	Yes No	Endstage renal disease (Kidney failure)	Yes No
Diabetes	Yes No	Head injury	Yes No	Urinary insufficiency	Yes No
Thyroid Disease	Yes No	Migraine h/a	Yes No	Obesity	Yes No
Cancer	Yes No	Tremors	Yes No	Drug abuse	Yes No
Immune disorder	Yes No			Sexually transmitted dis.	Yes No

**Other Medical History**


Surgical History (circle 'yes' or 'no')

Appendectomy	Yes	No	Coronary Bypass Graft	Yes	No
Cardiac Catheterization	Yes	No	Hysterectomy	Yes	No
Hernia repair	Yes	No	Tonsil & Adenoidectomy	Yes	No
Carotid artery surgery	Yes	No	Heart surgery / Angioplasty	Yes	No

Other Surgical History

_____
_____
_____
_____
_____
_____

Tobacco Use

Yes No Quit \_\_\_\_\_ (quit date)

Packs/day \_\_\_\_\_

For how many years? \_\_\_\_\_

Alcohol Use

Yes No

# of Drinks/Week  Can(s) of beer each week

Shot(s) of liquor each week

Drink(s) containing 0.5 oz of alcohol each week

Exercise

Yes No

If yes, how much? Rarely  Occasionally  > 3 times / week

Family Health History

	Living? (L) Deceased? (D) Unknown? (U)	Medical Conditions
Mother		
Father		
Mother's Mom		
Mother's Dad		
Father's Mom		
Father's Dad		
Sister		
Brother		
other		

Review of Systems

Do you presently have any problems or symptoms in the following areas? Check No or Yes

System	No ✓	Yes ✓	Comments	Physician comments
<b>ALLERGIC/ IMMUNOLOGIC</b> Low resistance to infection Environmental allergies	____ ____	____ ____		
<b>CARDIOVASCULAR</b> Chest pain or angina Irregular heart rhythm	____ ____	____ ____		
<b>CONSTITUTIONAL</b> Recent weight changes Good general health lately Recurrent fevers, chills, sweats Extreme fatigue Frequent nausea, vomiting Difficulty sleeping	____ ____ ____ ____ ____ ____	____ ____ ____ ____ ____ ____		
<b>EAR, NOSE, and THROAT</b> Change in hearing Ringing in the ears Recent nose bleeds Chronic sinus problems Voice changes	____ ____ ____ ____ ____	____ ____ ____ ____ ____		
<b>EYES</b> Changes in vision Glaucoma	____ ____	____ ____		
<b>ENDOCRINE</b> Heat or cold intolerance Excess thirst or urination	____ ____	____ ____		
<b>GASTROINTESTINAL</b> Change in appetite Severe heart burn Vomiting blood Frequent diarrhea Constipation Black or bloody stools Abdominal pain	____ ____ ____ ____ ____ ____ ____	____ ____ ____ ____ ____ ____ ____		
<b>GENITOURINARY</b> Blood in urine Burning with urination Difficult/frequent urination Lack of bladder control Sexually transmitted disease Change in sexual function	____ ____ ____ ____ ____ ____	____ ____ ____ ____ ____ ____		

<b>HEMATOLOGIC/ LYMPHATIC</b> Easy bruising Frequent bleeding Enlarged lymph nodes	____ ____ ____	____ ____ ____		
<b>INTEGUMENTARY</b> Unusual or prolonged rashes Breast pain or lump Change in hair or nails	____ ____ ____	____ ____ ____		
<b>MUSCULOSKELETAL</b> Joint swelling Difficulty walking	____ ____	____ ____		
<b>NEUROLOGICAL</b> Headaches Numbness/tingling sensation Weakness or paralysis Convulsions or seizures Change in memory/concentration Loss or blurring of vision or double vision Black-out/dizziness Memory loss or confusion Facial Pain/Generalized Pain Other neurological problems	____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____	____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____		
<b>PAIN</b> Joint stiffness or pain Muscle pain Neck pain Back pain Other pain	____ ____ ____ ____ ____	____ ____ ____ ____ ____		
<b>PSYCHIATRIC</b> Nervousness Depression Other	____ ____ ____	____ ____ ____		
<b>RESPIRATORY</b> Breathing problems/shortness of breath Coughing up blood Chronic cough	____ ____ ____	____ ____ ____		



Stanford  
HEALTH CARE  
STANFORD MEDICINE

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***You must hand carry the actual films or CD and records to your appointment.***

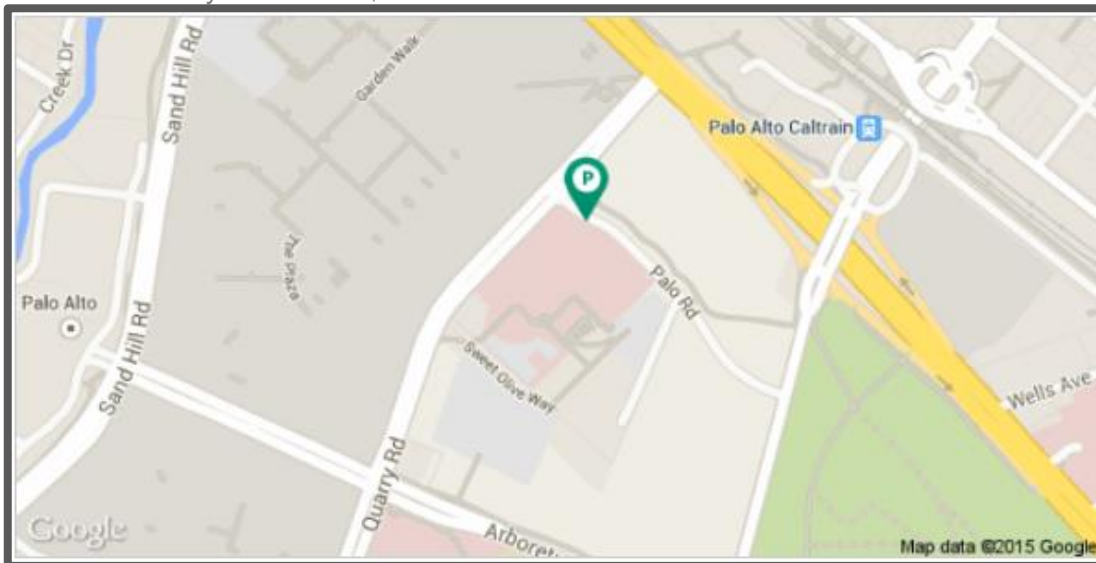




**Visitor Parking**

**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